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COMMUNITY HEALTH NURSE EVALUATION: THE STAKEHOLDER'S PERSPECTIVE

by

Ⓒ SANDRA CHRISTINE TENOVE

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
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To Michael Dennis Little

Every gain deserves an effort,
every effort deserves a gain,
however great that might be

Abstract

The purpose of this study was to investigate the perceptions of community health nursing stakeholders toward the evaluation of competencies of community health nurses as employed in Alberta. An attempt was also made to investigate how these perceptions might apply to the AARN Nursing Practice Standards as a program of evaluation.

The study was completed in two stages. The first round involved Board Members, Nursing Supervisors and staff nurses from eleven health units. Respondents were requested to generate nursing competencies, reflect on present methods of evaluation, and speculate on ideal methods to evaluate staff nurses. Findings from the first round were presented to staff nurses and Nursing Supervisors in eleven health units in a second round of data collection. Respondents were requested to validate round one findings and speculate on the use of the AARN Nursing Practice Standards and identified competencies in community health nurse evaluation.

Several methods of data collection were employed in an attempt to increase the richness of the data obtained and to increase exposure to the study. Tape recorded interviews, mail questionnaires and document review were used in the first round; group interviews and mail questionnaires were used in the second. Content analysis and descriptive statistics were used to analyze the data.

A total of 60 competencies were generated in the first round of data collection; 45 of these were validated in the second round using 80% agreement as a standard for validation. When asked to suggest criteria that might be used to measure each competency, participants tended to suggest sources for evaluative data rather than particular behaviors that could be assessed to indicate the level of performance of a particular competency.

A document review of evaluation methods employed in health units revealed that several methods of evaluation were used and there was no consistency across the health units surveyed. Supervisors expressed slightly greater satisfaction with the methods than did nurses. Nurses expressed a desire for methods of evaluation employing a broader data base.

Statements differentiating community health nursing from other practice areas were made by first round respondents, nine of these were agreed upon by a majority of second round respondents.

All respondents involved in the study expressed belief in the possibility that competencies applicable to the community health setting could be successfully used as a basis for evaluation. Respondents in the second round acknowledged the use of the AARN Standards in community health practice but found it difficult to apply the standards as a method of evaluating individual nurses.

The results implied that it would be possible to develop a set of competencies acceptable to stakeholders for the evaluation of staff nurses. Further investigation needs to be directed to the identification of these competencies and verification through field observation.

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I. OVERVIEW OF THE STUDY

A. Introduction

The contemporary importance of accountability, management efficiency, and cost control of expensive social planning has resulted, according to Broskowski, Attkisson, Tuller and Berk (1975:1), in an accelerated interest in program evaluation and associated personnel evaluation. Nowhere is this possibly more evident than in the health service field as governments attempt to reduce costs yet provide comprehensive health care services to the populace. Lang (1980, editorial) states that evaluation or assessment of health care meeting high standards of quality is a critical problem in health service delivery. She suggests that many variables must be considered in quality assurance but emphasizes human values and the knowledge levels of both provider and consumer.

The subject of assessing and assuring quality has been addressed within the nursing field in recent years through measures such as defining nursing practice and setting standards for such practice both on a provincial (Alberta Association of Registered Nurses, hereafter to be referred to as the AARN, 1981) and on a national level (Canadian Nurses Association, hereafter to be referred to as the CNA, 1980). A logical outcropping of this concern for nursing practice and standards is the issue of competency testing. Cohen and Haney (1980:5) suggest that competency testing embodies the tradition of governments, through social policy, to promote minimum levels of social welfare. There has been a shift in emphasis from delivering services to securing results. Nurses have been pressured to maintain, prove, and improve their competence in nursing practice. References to competence prevail in the written and unwritten codes of conduct (American Nurses Association, 1976).

Spady (cited in Finch, 1980:398) suggests that there is a fundamental need in organizations to develop a universally acceptable definition of competency, a best method for testing such competency, and proper criteria for distinguishing between competent and incompetent individuals.

B. Significance of the Study

Nursing, as with other professions, during the past few years has come under government and public scrutiny as a human service supplier. Nurses, as portrayed in the provincial and national nursing associations, have accepted this emphasis in order that they may limit outside control and maintain professional integrity and autonomy (Bowman, 1973:78). The nursing associations have taken steps to define nursing from their perspective, and to set standards for nursing practice in line with the selected perspective (AARN, 1981; CNA, 1980).

There have been multiple efforts in this regard. Each provincial association across Canada has set standards in response to public and professional inquiry. The CNA has reviewed these individual efforts and attempted to produce national standards which reflect the provincial concerns. However, no one set of standards has been accepted nationally; individual provinces have pursued their own.

In Alberta, an Ad Hoc Committee on Nursing Practice Standards of the AARN was formed to examine and set nursing practice standards that would be applicable to all practice areas. In a report by the Nursing Practice Standards Committee to the AARN Provincial Council February 12, 1981, a plan for implementation of the proposed standards was presented and commitment gained from the Association for a five year program to develop criteria in selected nursing areas and to develop measurement techniques for evaluation of these criteria.

Because community health nursing, as a nursing practice area, was to be included in the evaluation scheme proposed in January 1981, and because some community health nurses believed there were differences in the standards, competencies, and evaluation criteria for community health nursing, an assessment within this select field seemed imperative.

Archer and Fleshman (1975:358) state that community health nurses have been distinguished from other nurses not only because of the setting in which they practiced but also because they had advanced preparation, higher education, and often some form of certification. This is no longer true as more specialized nursing services, such as home care services, have moved to the community and community health nursing skills have been recognized as relevant to practice in other areas. The authors suggest that unless community health nurses can differentiate their area of practice and expertise from the area of those adopting the expanded community orientation within their field, it is possible that community health nursing could be integrated out of existence. These facts indicated that the development of evaluation criteria and the recognition of community health nursing competencies was of importance to the stakeholders.

In discussing the Alberta plan with AARN council representatives (Middleton, 1981), it became apparent that no needs assessment had been conducted, that a competency based evaluation format had been arbitrarily selected, and that no specification had been recorded which identified the purposes for and usages of the evaluation results. While a statement had been made that the criteria for evaluation of the relatively arbitrary standards was to be developed in the affected nursing practice areas (AARN, 1981), no identification of the process to be used, and the respondents involved, had been made.

The federal and provincial associations, in their evaluation program, have arbitrarily set nursing standards and have not as yet included community health nurses, Board Members, or Nursing Supervisors in the identification and applicability testing of such measures. Havelock (1973:20) suggests that the inclusion of stakeholders in such determination increases the longterm acceptance of such organizational changes.

The plan for implementation of the Alberta evaluation program set June 1981 as a target for initial field study to establish criteria and 1982 as the target for evaluation program implementation. Participation in these early stages was to be voluntary with the hope of developing an overall system of study.

Because of the time constraints imposed by the Association on such preparatory workup, this study, if it was to be of any use, and significance, had to predate the initial implementation program scheduled to begin June 1981. In this regard, discussions were held with the AARN Evaluation Committee (Sellers, 1981) and assurance was given that the evaluation program would not proceed to the community health arena until possibly fall 1981 to Spring 1982 because of the possibility of this study being carried out prior to their intervention.

The political nature of the evaluation scheme and the involvement of both the provincial and the national associations in the eventual outcome as well as federal and provincial government involvement must be considered in the commitment to a needs assessment in one selected nursing arena. Because of the emphasis by the Alberta government on the use of nursing services outside the hospital (in an attempt to reduce costs and yet provide comprehensive care to the populace), and because of the accepted differences in perspectives taken by community health nurses as opposed to hospital nurses, a needs assessment at the time of the study seemed desirable.

C. Statement of the Problem

The purpose of this study was to investigate the perceptions of community health nursing stakeholders toward the evaluation of competencies of community health nurses as employed in Alberta health units. To this end, the following problems were delineated for Round I data collection:

1) What was the state of the art of community health nurse competency evaluation at the time the study was undertaken?
    a) what methodologies were employed?
    b) how were the results of the evaluations used?
    c) what degree of acceptance was present with the methodology and usage by identified stakeholder groups?
    d) what degree of satisfaction was experienced by identified stakeholder groups with respect to the present evaluation process?
2) What expectations were held by the identified stakeholder groups as to
    a) the usage of, and
    b) the methodology employed in

    evaluative processes for the position of community health nurse?
3) What competencies were considered necessary for successful performance in the position of community health nurse?
    a) what criteria might be used to measure such competencies?
    b) could these competencies be ranked in importance?
    c) if competencies could be ranked, what ranking was obtained? and what was the significance of that ranking?

Analysis of Round I data was directed to the following types of questions:

1) Did the identified stakeholder groups share common opinions regarding the evaluative processes they presently employed?
2) Did the identified stakeholder groups share common expectations regarding the evaluative processes desired?
3) What competencies were considered necessary for community health nurse performance?
4) What criteria were considered necessary for the evaluation of community health nurse competencies?
5) What priorities were set with respect to the generated competencies?
6) What priorities were set with regard to the implementation of an evaluative process?

The purpose of Round II was to validate Round I data and speculate as to its possible use as a program of evaluation. To this end, the following questions were delineated: What was the reaction of stakeholder groups to:

1) the community health nursing competencies generated in round one?
    a) was there agreement with the competencies generated?
    b) could some competencies be deleted? added?
    c) could additional criteria for measurement be generated?
2) the methods of evaluation used by round one health units?
    a) were these methods representative of those employed by the second sample?
    b) were the ratings of satisfaction representative?
    c) were the choices of ideal evaluation methodologies representative?
3) the use of competencies to form the basis of an evaluation?
4) the use of the AARN Nursing Practice Standards in evaluation?

Analysis of Round II data was directed to the following types of questions:

1) what was the extent of group agreement as to the representativeness of the identified competencies?
2) what criteria were considered necessary for the measurement of each competency?
3) what differences existed between community health nursing practice and other practice areas?
4) were common opinions expressed within the groups regarding the evaluation processes employed?
5) was competency evaluation seen as an acceptable method of evaluation in the community health setting?
6) could identified competencies be assigned to each of the AARN Nursing Practice Standards?
7) could AARN Nursing Practice Standards be used to evaluate community health nursing practice? How?

D. Assumptions

It was assumed that:

1) the competencies required for community health nursing could be identified.
2) competencies could be recognized by community health staff nurses, Nursing Supervisors, and Local Health Authority Board Members.
3) the three groups – staff nurses, Supervisors, Board Members – as data sources for this study were the most relevant population to consult.
4) all respondents were honest and truthful in their opinions and judgments regarding their perceptions of community health nursing competencies and evaluation.

E. Definitions

For the purposes of this study, the following definitions were used for the terms listed below:

Evaluation – the process of delineating, obtaining, and providing useful information for judging decision alternatives (Worthern & Sanders, 1973:129).

Performance – the ability to perform; capacity to achieve a desired result; the act or process of carrying out something; the execution of an action (Schneider, 1979:1).

Needs Assessment – a study in which data are collected for estimating the needs of a group, community, or organization thereby providing decision-makers with information for action (Polit & Hungler, 1978:215).

Competence – the quality or state of being functionally adequate or of having sufficient knowledge, judgment, skill, or strength (Schneider, 1979:1).

Competency – An intellectual, attitudinal and/or motor capability derived from a specified role and setting, and stated in performance terms as a broad class or domain of behavior (Peterson 1978:3). For the purposes of this study, competency is further defined as those characteristics (knowledge, attitudes, or ways of doing things) that a community health nurse must have to be considered 'competent' in his/her job.

Criteria – the standards or guidelines that can be used to measure a specific competency.

Community health – two definitions of community health were used; the first to indicate the nursing practice area and the second to emphasize the community nature of such practice. Community health has been defined thusly by the National League for Nursing, USA, May 1959:

> Community health nursing is a field of specialization within both professional nursing and the broad area of organized public health practice. It utilizes the philosophy, content, and methods of public health and the knowledge and skills of professional nursing. It is responsible for the provision of nursing service on a family-centered basis for individuals and groups, at home, at work, at school, and in public health centers. Public health nursing interweaves its services with those of other health and allied workers, and participates in planning and implementation of community health programs.

Herman (1968:8) emphasizes the community nature of the nursing service in his definition:

> Community health services refers to those services geared to providing for the state of well-being of the community. Community health emphasizes not only the additive health of the individuals who constitute the community, but the condition of those structures, facilities, and patterns of action that the community uses to conserve its collective health.

Community health nurse – any nurse employed by a health unit or local board of health in the province of Alberta. The terms "CHN" or "nurse" are used interchangeably in the study.

Health unit – those health facilities operated under the jurisdiction of the provincial government which provide mainly preventive health services to the community. In this study the term will be applied to those institutions operated as health units or, in the case of Edmonton and Calgary, as health clinics under the Local Boards of Health.

Board of Health – the Local Health Authority (L.H.A.) responsible for providing a minimal level of services to the population within the health unit boundaries, as specified by provincial regulations. Services emanate from a health unit office or regional clinic.

Nursing Supervisor – the most senior nursing position in a health unit or the Local Board of Health. Actual position titles may refer to Nursing Supervisors, Senior Nurses, or Directors of Nursing.

Stakeholders – those persons having expectations, needs, and/or involvement in the outcomes of the decisions to be made or the alternatives to be chosen. For the purpose of this study, the following groups have been identified as stakeholders:

1) community health staff nurses;
2) community health Nursing Supervisors; and
3) Board Members.

Validation – a term used by Manuel and Deane(1977) to describe the second phase of their approach to curriculum development. This phase involves submitting the profile developed by a small selected group of practitioners in a specific occupation to the scrutiny of a larger segment of the occupation to ascertain the extent of agreement with the original profile.

F. Design of the Study

The central aspect of the study design was the active participation of identified stakeholder groups to describe the perceptions toward community health nurse evaluation. As a forerunner to any evaluation, Alkin (1973) notes that a needs assessment will provide the information necessary for estimating the need of the selected groups and in this case the nursing profession as a whole.

Interviews and questionnaire surveys were used to investigate the nursing community and to find out what priorities, if any, had been set for identified needs and goals in relation to nursing evaluation in the community health arena.

Because of the time constraints imposed by the then ongoing AARN evaluation program, the methodology involved three phases:

1) As a forerunner to the actual data collection, interviews were held with key informants (Nursing Supervisors, community health staff nurses, and Local Health Authority Board Members) on a referential basis. Among these informants, particular attention was paid to those with nursing background as it was believed that they were in the best position to know the needs of such evaluation. In addition, knowledgeable persons from the nursing associations were interviewed with respect to the development and setting of the nursing practice definitions and the present standards.

2) Round One Data Collection

   A survey through open-ended questions in semi-structured interviews was completed on a sample from the target groups to gain information on the state of the art and the expectations of the stakeholders for any type of evaluation. The same questions were included in a written questionnaire that was made specific to (a) community health nurses, and (b) Local Health Authority representatives. This action was supplemented by selected interviews so that comparisons might be made between method and data richness. The use of questionnaires for these two groups was deemed necessary because of technical problems in arranging interviews during the holiday and harvest season.

3) Round Two Data Collection

   A survey was completed on a second sample using the information gained from the first round to allow reaction, confirmation, and the setting of priorities for identified needs, competencies and criteria. This survey included both questionnaires and group interviews. The AARN Standards for Nursing Practice were presented to gain reactions as to their individual feasibility for use in the evaluation of community health nurses, and the feasibility of using the standards in conjunction with the competencies generated in round one.

Sample

A sample of the community health population employed in Alberta health units was selected on the basis of availability and potential as an information source.

Three groups had been identified as having some stake, expectations, and/or involvement in the final outcome of this and any study dealing with community health nursing competencies. These groups included:

1) the community health staff nurses – those persons who had been and would continue to be evaluated;
2) the community health Nursing Supervisors – those persons who are usually required to "do" the evaluations of community health nurses; and who represent the administration common to all health units,
3) the Board Members – those persons who are elected to office, appointed to the health unit board, and control the funds provided by the province to carry out health unit programs. Because of their elected status, and residence in the local community, it is suggested that these persons can be considered representative of the health consumer or public at large.

Two samples were surveyed from the total population of the members of the twenty-eight health units. The province was divided in two with samples including representation from north, central, and southern Alberta with attention to matching rural and urban service characteristics. Round one participants were asked to report on their evaluation methodologies and their perceptions of the competencies required by community health nurses. Round two participants were requested to react to the initial findings, to suggest criteria for measurement, and to provide perceptual evaluations of the adequacy of the existing standards for evaluating nursing care in the community health arena.

G. Delimitations and Limitations

Delimitations

1) This study was delimited to the consideration of community health nursing evaluations as affecting staff nurses employed in health units in

the province of Alberta.

2) An approach was developed to the evaluation of community health nurses on the basis of information gained through a needs assessment; the development of specific evaluation tools was not entertained.

Limitations

1) As health is a provincial responsibility under the B.N.A. Act each province and health care organization necessarily reflects the philosophy of the current individual government toward the delivery of health service. The results gained from this study cannot therefore be generalized to any other provincial community health system nor to any other health care delivery system.

2) This study was focussed on the perceptions of selected stakeholder groups as an indication of the actual competencies of the nurses themselves.

3) The respondents were volunteers and may have been atypical of the population as a whole. The findings of the study were descriptive of the three selected stakeholder groups and therefore are directly applicable only to the personnel involved in the study.

H. Organization of the Thesis

This thesis is organized into eight chapters. The first four comprise the introduction, a literature review in which emphasis is given to the state of the art of community health nurse evaluation, a presentation of the conceptual framework underpinning the research and a description of the research methodology. In the fifth and sixth chapters the findings of the first and second rounds of data collection are presented. The seventh chapter presents the discussion of the data, and in the eighth and final chapter conclusions are drawn, implications for nursing practice are suggested and recommendations are made for future study.

II. REVIEW OF THE RELATED LITERATURE AND RESEARCH

A. Trends in Nursing Research: 1960 - 1982

Over the past two decades, nurses have become recognized as members of the scientific community, demonstrating and receiving recognition for competence and productivity in intellectual arenas (Schlotfeldt, 1975). The focus of nursing research has varied from theory verification to theory development as it relates to nursing practice (Schlotfeldt, 1975) to a recognition of the worth of historical and philosophic inquiries and the benefits of examining educational and administrative science. The new rule for research is pluralism of approach.

Newman (1972) identified the need to develop theory that is not only relevant to nursing but also basic to nursing. She describes nursing as an entity

> beginning to realize its own potential for discovering a particular kind of knowledge that is relevant to other disciplines and essential to nursing.

Nursing is viewed as neither totally dependent upon nor independent of other disciplines.

While the importance of theory development in nursing has been emphasized in the literature (Benoliel, 1977; Newman, 1972; Schlotfeldt, 1975). McFarlane (1980) suggests that present literature does not reflect that the task is being adequately carried out. The nursing theories that have been proposed appear to lack the data that can support them as structures that guide, shape, and control reality.

McFarlane (1980:4) continues on to suggest that the professional purpose of nursing is action-oriented and therefore requires theory of the highest level, i.e. that which guides action toward the production of desired situations. McFarlane proposes a "situation-producing theory" which assists nurses to identify appropriate goals and which facilitates the achievement of those goals. Three essential ingredients of such a theory include:

1) goal content specified as the aim for activity,
2) preparations for activity to realize the goal content, and
3) a survey list to serve as a supplement to present prescriptions and as a preparation for activity toward the goal content (Dickoff and James:1968:201, cited in McFarlane, 1980).

King, Orem, Rogers, and Roy (cited in McFarlane, 1980) have all proposed theories for nursing. Yet each proposal varies when examined according to the ingredients of a situation-producing theory. All four proposals are useful when examining the nurse in a unique setting. Perhaps a new theory can be developed using components of all four proposals which would make the theory unique to the setting and thereby introduce a greater understanding and control of the nursing reality.

Field (1980:13) suggests that

> a general survey of the field of nursing research is difficult due to the wide variety of topics normally selected for study and the variety of approaches used for classification.

This trend is even more notable when examining methodological trends with specific emphasis given evaluation, particularly community health nursing evaluation.

Stinson (1979) and Field (1980) note that nursing uses more varied and diversified approaches to research methodology than possibly any other academic or professional discipline, but has tended historically to rely heavily on quantitative methods. Stevens (1978, cited in Field, 1980:14) has suggested that in

> an effort to be scientific, the nursing researcher has often selected an approved methodology and then sought the nursing question which lends itself to that methodology. This, in turn, has led to trivial research which has failed to identify significant nursing questions.

Field (1980) cites, and is supported by the criticism of others, (Crawford, Default and Rudy, 1979; Donaldson and Crowley, 1978; McKay, 1977, Schlotfeldt, 1975) an approach to research which relies solely on traditional empirical methods (i.e., the use of deductive approaches to hypothesis formation, large statistical samples, and analytical frameworks based on quantitative design). Kilty (1976) cautions nurses about making the same fundamental mistakes as those made in educational research:

1) in isolating variables and in studying relationships between variables, research designs have often been clinically *clean* and as a result remote to the real situation in education;
2) the results of research have not been immediately translatable into action appropriate to the education arena.

Kilty (1976:102) warns that research, whether in nursing or education, must be sensitive to the needs of those directly affected by its outcome and must foster a spirit of awareness and support by the members of the field. The overwhelming need for emphasis to be placed on alternative methods of research that are based on the needs of the area to be studied has received much attention in the literature recently.

Crawford, Default and Rudy (1979:350) comment on an apparent shift from preoccupation with method to an emphasis on first asking significant questions about nursing phenomena and then finding appropriate methods for investigation. They state:

> the urgent task for nursing is to continue to clarify and make more explicit the unique perspective and focus of nursing

While Field (1980) has noted and used observational methods of inquiry which included detailed observation of the nurse in action, other observational and descriptive methods can provide data which provide insight into the particular world of the nurse.

Highriter (1977) analyzed and categorized 115 studies directly related to community health nursing. Most of these used survey methods to obtain data and were directed to the evaluation of service, i.e., programs, technical performance and the performance of the nurse in her role. In the studies which evaluated performance effectiveness, the two most common indicators used were statistical data on client outcomes and the incidence of detection of patient defects and/or problems. In her review of these studies, Highriter suggested that most of the indicators were easily quantifiable, questioned the validity of attitude change studies based on operational definitions, and suspected the conceptual bases of the selected tools. She noted the particular difficulties in establishing adequate control groups and the problems associated with obtaining large enough samples to claim statistical significance. Most studies documented by Highriter appeared to be concerned with program success as opposed to nurse performance and viewed such success as a function of the number of clients processed rather than the quality of the care given or of the performance of the individual nurse.

Some of the studies (Hunt, 1972) done on health visitors (the British counterpart to community health nurses) have been motivated by difficulties encountered in establishing evaluation criteria. Hunt (1972:23) states:

> a good deal is written on what health visitors should do but little on how they should do it, so there is no clear objective standard by which judgment of their work performance can be made.

Despite the move to study nursing through observation of the interaction between the nurse and client, little attention has been paid to the influence of the organizational structure or the priorities of the nurse herself on her behavior. Dingwall's

(1977) study suggested that students are influenced more by the attitudes of nurses in the field than by the values transmitted in the educational system. Field (1980:30) notes that to create change one must identify, understand and study the basic problem. "What is happening" must be known before "why it is happening" can be identified.

B. Evaluating Nursing Performance in the Community Health Arena

Professionals are granted authority over functions vital to themselves and are permitted considerable autonomy in the conduct of their own affairs by a recognition of the social relationship between society and the profession. In return, the professionals are expected to act responsibly, always mindful of the public trust. Phaneuf (1972:xi) notes that self-regulation to assure quality in performance is at the heart of this relationship.

Accountability in nursing practice has been described by Passos (1975:80) as the "dues paying" aspect of the increasing emphasis in nursing on greater autonomy and independence for the nurse practitioner. While personal autonomy has been regarded as the freedom to conduct tangential work activities in whatever manner one desires, Engel (cited in Mauksch, 1975:3) defined professional work autonomy as the freedom to practice in accordance with training. Such professional autonomy appears critical for individual performance if the nurse is to provide the quality of service demanded by the profession and by society. Both Passos (1975) and Mauksch (1975) suggest that the manifest destiny of an occupation can be reached only if each member of the occupation is in control of the activities and attains the goals set forth by the group as a whole. To gauge this autonomy the individual must be evaluated.

The steps taken by the nursing associations on a federal and provincial level to develop standards to ensure safe practice and the competency of its practitioners are evidence of the acceptance of public demands for accountability (AARN, 1981; CNA, 1980).

Can community health nursing be defined? Is it a specialty? Does it represent an expanded role of the nurse? The next sections will focus on this problem of definition plus the significance of nursing performance evaluation, and the methodologies available and appropriate to nursing and in particular community health.

Community Health Nursing: An Expanded Role?

A nurse is a nurse is a nurse. Few nurses within the profession would believe this to be true. Indeed the old scenario, with the nurse in white providing tender loving care to the patient at bedside is no longer the mode of behavior, as McIntyre (1973:54) notes:

> as health services become more complex, the variety of areas in which the nurses practice becomes more extensive, and sometimes the relationship to the recipient becomes more distant

Phaneuf (1972:xi) notes that in every setting, the scope of nurse responsibilities, and of her competence has expanded considerably. More and more, the nurse functions as an autonomous professional, equal to other members in a team, and subject only to remote and tenuous supervision by administrative superiors.

Community health nursing is more than curative health nursing which has been extended into the home environment; it is a concern for the promotion of healthy lifestyles of the client, the family, and the community. Community health nursing has been defined in the following manner by the Canadian Public Health Association (1977:3):

> community health nursing is professional nursing that focuses its attention on the health needs of people throughout their life span on a health-illness continuum. In collaboration with the client and other health workers, the nurse combines a knowledge of community health problems, practices, and resources, and the nursing process. She thus assists the individual, family and/or community to assume responsibility for sound health practices and to achieve an optimum state of health and self-reliance...

Hunt (1972) in a description of health visitors, noted:

> there seems to be a common feeling among health visitors that their role is difficult to interpret to others and that it is not well understood or agreed upon by those with whom they work

This feeling of alienation yet uniqueness is corroborated by Davis (1976) in a study of nurses working in community mental health settings.

Hunt (1972:20) provided some evidence to suggest that health visitors occupied a "fringe position in nursing" and shared only a tenuous sense of identity with nurses engaged in curative nursing.

In both the Hunt (1972) and Davis (1976) studies, skills claimed as distinguishing the activity of the nurses involved were seen as skills claimed across occupational lines. With such a broad definition of health visiting responsibilities and competence, Hunt felt nurses easily invaded the realm of other professionals; yet such competencies may or may not have been based on specific knowledge and expertise.

Can community health nurses be distinguished from other nurses because of the setting in which they practice? Because of their advanced preparation? Higher education? Has the movement of more specialized nursing services into the community caused a recognition of community health nursing skills as relevant to practice in other arenas? Archer and Fleshman (1975:358) suggest that unless community health nurses can differentiate their area of practice and expertise from the area of those adopting the expanded community orientation, it is possible that community health nursing could be integrated out of existence. Is this a realistic possibility?

Williams (1977), maintains that there is a distinct difference, even today, between community health nursing and clinical practice. It is more than family-oriented care delivered outside the institutional setting; it is a matter of focus on group health problems, present and projected, in contrast to individual, clinically-oriented care.

Is community health nursing a specialty? Does it constitute an expanded role? What is an expanded role? Different concepts of the expanded role of the nurse are becoming evident from positions taken by nursing organizations and from legislative developments. One expansion concept is based upon the nurse as a practitioner who is to be granted greater independence to pursue a discipline called professional nursing. Implicit in this concept is the attempt to create for the professional nurse a role comparable to that of the physician, as an independent practitioner. In this parallel to medicine as a clearly separate profession, emphasis is placed on advanced academic study for nurses. Not all currently registered professional nurses would be considered qualified or even candidates for such practice according to the advocates of this expanded role concept (Hersey, 1975:136).

Green (1971:151) and Schlotfeldt (1973:32) note that over the years the community health nurse has demonstrated a capacity for the expanded role in preventive services, health promotion, and in care and treatment in the community setting, and needs only more opportunity to show what she can do. Expanded education is not considered a necessity; instead the opportunity to use one's capabilities is seen as paramount. In the last ten years, according to Chaska (1978), this opportunity has increased, yet the full capabilities remain untapped when the goal is primary care by an independent practitioner working in a specialized field.

Griffith (1980), in discussing the results of a study on Supervisors' ratings of baccalaureate nurse competencies, noted that community health nurses were rated higher on over half the competencies. While many postulates were generated for this result it was suggested that increased breadth of responsibility, autonomy, and practice was granted to nurses in community health settings.

Yet, have community health nurses succeeded in establishing and meeting their required competencies? Flynn et al (1978:633) suggest that attempts to integrate preventive and therapeutic health services with the planning, delivery, and evaluation of nursing services responsive to community needs and priorities, are often blocked by

1) narrow definitions of community health that limit the practice setting,
2) difficulty in distinguishing between nursing, medicine, and community health practice, and
3) scarcity of service settings in which the individualistic clinical approaches are effectively integrated with the community health strategy of focusing on aggregate groups.

Williams (1977:253) contends that if practice is to be consistent with community health philosophy, attention must be given to the influence of environmental factors (physical, biological, and sociocultural) in the health of populations, and priority must be given to preventive and health maintenance strategies over curative strategies.

The Significance of Nursing Performance Evaluation

Passos (cited in Dracup, 1979:24) advocates nursing as "a social process in which human beings are continually interacting with other human beings in ways that are imperfectly measurable or predictable." Dracup (1979) suggests that in response to the failures of evaluations, a systematic response based on assessment of needs, time frame, and progress must lead to self-appraisal. The establishment of standards for nursing is a step toward efficiency in offering the kinds of service needed to meet the demands of society and the changing world and simultaneously satisfy the needs of the professional practitioner (Fivars and Gosnell, 1966:201; Prembrey, 1979).

Ellis (1979) debates the issue of assigning credentials (and the components of accreditation, licensure, and certification) and the ramifications of proposed changes on nursing. Ryan (1981), in discussing professional burnout, notes the blurring of roles and suggests that nurses must redefine expectations to match the amount of power and the level of competence as a profession.

Ryan (1981) and Ellis (1979) applaud nurses taking stands on what constitutes nursing practice. It is only through such definitions that evaluations can take place for one cannot evaluate what one cannot define. This is perhaps the greatest problem that nurses have today, as professionals and as individual practitioners. The program of the APHA Convention for April 1981 seemed to reflect the concern of the health care field , particularly the nursing component with respect to ensuring practitioner credentials.

Existing Evaluation Methodology

Methodology Used in Nursing Performance Evaluation

There are perhaps as many methods of evaluation as there are nurses to evaluate. Traditionally, evaluative focus on nursing has been confined to the hospital setting (Williams, 1977; Fivars and Gosnell, 1966; Phaneuf, 1972) where the majority of the nursing profession is employed. Methods range from anecdotal notes (Voight, 1979:30) which focus on perceived strengths rather than weaknesses, critical incidents (Flanagan et al cited in Fivars and Gosnell, 1966:147) which identify behaviors believed to be critical to the performance of nursing functions, and peer review (Phaneuf cited in Downs and Fleming, 1979:9) which require a conceptual base consistent with the institutional philosophy, to elaborate systems such as those offered by Wyman and Fernau (1977) and Schwirian (1978).

Schwirian (1978) describes the development of a six dimensional scale of nursing performance. This measure, which has many similar aspects to the AARN nursing standards framework of 1980, was developed so that it would be applicable to nursing performance in a variety of settings, consistent with a nursing process model, and applicable to the practice of nurses who had completed their basic nursing education within the past 1 to 2 years. The tool is usable by nurses to assess their own performance and also by their immediate Supervisors. It is composed of items stated in observable nurse behaviors that can be read and interpreted consistently without additional explanation or expansion. While the results of the study are impressive in terms of data collected, the process for such development is prolonged and dependent on the efforts of those involved and their willingness to abide by the scales derived.

All these methods are applauded in their particular foci, however, many gaps remain in the coverage of nursing performance appraisal. Weckworth (1977:51) suggests that too much emphasis is given to the components of the evaluation process and that in the health care field one must begin at the end and work backwards making the consumer of services an active participant in the process.

This client/consumer concern is echoed by Hover and Zimmer (1978) as they note that all quality assurance programs include the evaluation and improvement of care and must therefore include the evaluation of patient outcomes. The authors describe a system which defines its population groups broadly thereby reducing the number of criteria sets required. Standards are not set until after the first evaluation on the premise that such standards are judgmental and that whereas standards in other fields may be set in relation to accepted norms or requirements, data are usually not available for establishment of normatively based standards in nursing.

Glasser (1961) in reviewing a study designed to evaluate performance of public health nursing students but which was assumed to have relevance for public health practitioners as well, noted the problems of "having to evaluate according to individual input or according to supervisor intuitive judgment." It was as Glasser announced:

> difficult to judge professionals who perform non-quantifiable services and who work in teams.

The need for measurable behavioral criteria that accurately describe the levels of performance present on rating scales was emphasized. While Glasser was accorded some success in this venture, the scales developed now lack relevance to present community health practice.

Del Bueno (1979) suggests that performance evaluation should be a continuous process based on five elements: content, tools, training, rewards, and accountability. In keeping with Schwirian (1978), del Bueno notes that it takes about three to six months to develop appropriate tools and that critical incidents and anecdotal notes could be used to distinguish between critical and desirable behaviors.

These methods all have common elements: nursing behavior must be observed to be evaluated; nursing performance must be evaluated on the basis of outcomes of that performance, and the consumer interest must be addressed directly or indirectly in all performance evaluations.

Applicability of Methodology to Community Health

Flynn and Ray (1979) are supported by Archer and Fleshman (1975), as they note that "those of us in community health nursing are keenly aware of the need to document the effectiveness ... of (our) services." However, are the methods used for evaluation of hospital nursing practices applicable to the community health arena?

Flynn and Ray (1979) describe the commonly used methods for evaluation, record audits (Phaneuf, 1972), supervisory review, and peer review and note problems of generalizability and consumer appropriateness. They note, as does Williams (1977), the confusion over the definition of community health nursing and suggest that criteria to evaluate such nursing should include levels of prevention, health status of aggregate populations, influence of environmental factors, community involvement, self-care versus self-reliance issues, and the need for active consumer participation.

Highriter (1977), in summarizing research in community health nursing, noted the absence of indicators or tools for program evaluation. Even less has been available on performance evaluation.

In measuring health care in the community arena, two methods have been tried, evaluating the health care setting, and evaluating the process and outcomes of the health care services given (Decker et al, 1979). This last process has been attempted with some success centering on the kind of care provided by home health services, the way it is being provided, and the effectiveness of the care in creating positive change in the health care status of the clients served. The study found that there was considerable agreement among nurses as to outcomes desired from specific health management and on developing outcome criteria for the client problems presented to the nurse on initial contact. The need to focus on aggregate groups led to the development of a data bank in the community nursing section. The limitation of this method is that it centers around patient care conditions which presuppose an illness criterion. This removes the emphasis from health promotion and maintains focus in the curative status of nursing practice.

Engle and Barkauskas (1979) offer perhaps the single performance evaluation tool specific to community health nursing. The Performance Evaluation Tool (PET) was suited to the specific needs and objectives of the agency and used to assess performance in four areas: clinical practice, supervision and management, professional growth, and research. Standards, were developed keeping in mind the necessity for identifying the unique components that differentiate community health nursing from hospital nursing. These components turned out to be a concern for the physical environment of the patient's home and community, concerns for community as a whole, and aggressive casefinding to identify persons most likely to benefit from community health nursing intervention. As with other attempts, the instrument drew favor through staff involvement and its evolution. It lacks generalizability to other health agencies because the criteria reflect the values and beliefs of the staff of the agency and because the instrument was made specific to the setting.

Both the AARN and the CNA have developed standards for nursing practice. The CNA's primary objective is to:

> promote high standards of nursing practice in order to provide quality nursing care for the people of Canada

As a result of this commitment, the association has developed a definition of nursing practice. Defining standards, however, is seen as only a preliminary step in the evaluation of quality nursing care; these standards still need to be adapted to specific practice settings whether community or hospital based.

An essential difference between the national standards and others is their emphasis on an explicit conceptual base for practice. On review it would appear that the AARN Nursing Practice Standards could be subsumed under the second standard of the CNA Standards which reads:

> Nursing Practice requires the effective use of the *nursing process* as the method for carrying out the independent, interdependent and dependent functions of nursing practice. – emphasis added, CNA, 1980

The two sets are therefore not mutually exclusive. If the one can be seen as applicable to the practice of nursing in a unique area such as community health, the other will also apply.

Adam (1981:33) suggests the use of a Henderson conceptual model for nursing practice in the community setting and proposes an adaptation of the second CNA standard to the uniqueness of that setting. The examples given for adaptation were

> necessarily incomplete and provide only a limited prediction of the considerable work that must be done at the regional level.

Adam also notes that nurses involved in a particular setting are the people best equipped to develop standards for that setting.

Field (1980) has suggested that through a nurse's activity one can ascertain her conception of the world, the client, and her relationship to each. From these perceptions and activities, one could perhaps gain more objective data by which to choose a model for theory (McFarlane, 1980; Donaldson and Crowley, 1978).

Koerner (1981), in a study on selected correlates of job performance of community health nurses, concluded that the broad scope of the standards permitted flexibility in defining related items that were appropriate for evaluating the job performance of nurses in a community health setting. This author would concur that the use of standards is paramount for developing quality assurance measures for nurses in any health care setting.

James (1962), in analyzing the basic principles of evaluation as they apply to community health, contends that the values and the validity of objectives for evaluation must be considered. Even when the needs of a population seem to be met, performance must be reconsidered in terms of cost efficiency.

Knox, (Alberta Public Health Newsletter, 1982) has recently completed a field experiment using a self-appraisal tool and relating its use with independent goal setting behaviors. She suggests that the tool allows community health nurses to identify personal strengths and weaknesses through the setting of job related, realistic and highly specific goals. The findings of this study are encouraging but Knox cautions that testing must be extended to a larger sample before the tool can be recommended for use.

The efficiency and effectiveness of community health nursing is of present and future concern. The National Conference on Nurses for Community Service (1973) concluded that :

1) a variety of nursing practitioners with varying roles and responsibilities will be required in the future to meet the changing needs;
2) active participation and involvement of the public in community health care planning is essential;
3) technical competence requirements must not override the need for behavioral and relational caring skills; and
4) the nursing profession must recognize its responsibility to the public and

accept an increasing degree of accountability for its actions.

The methods presented in these last sections do permit community health to examine its practitioners by selecting the focus of the evaluative endeavors and the proposed usage of the results.

Alternative Evaluation Methodology

While inroads have been made into the nursing field with regards to evaluation, much of the methodology has been borrowed from other fields such as business and education. Health care is young in its development in Canada compared to other countries and much of what we have can be attributed to the practices found in other countries. The practices in the United States have been presented in the last section as if they had been our own for the practices are similar. Do other countries have something to offer in this regard? Do other fields have methodologies that might be appropriate to the specificity of community health? These questions will be addressed in the following sections.

International Approaches to Nursing Evaluation

As community health nursing varies from country to country and even regions within those countries, it is difficult to clearly define and delineate those activities labelled community health nursing.

A common focus, however, exists in the quality of care and van Maanen (1979) suggests that more emphasis must be given to the outcome of care as the joint effort of the health team members rather than the distinguished professions and the individual provision of care. Van Maanen (1979:378) suggests that

> although the development of nursing standards and criteria require a sound knowledge of nursing and by preference should be carried out by nurses, it may be helpful to include other disciplines in a review

Unless one focuses on the common practices and philosophy of community health in a consideration of the performance of nurses, community health nursing practices cannot benefit from international comparison.

Alternative Professions Approaches to Evaluation

Business and education have, as human service suppliers, been involved with the evaluation of personnel longer than most. In light of their experience these fields have important contributions to make with respect to the establishment of performance appraisal methodologies.

Kilty (1976) states that education and health are necessities basic to the maintenance and development of society. Both areas are highly skill-centered in that they depend on the insights, attitudes and skills of the individual professional. In fact, he suggests that so many skills are demanded of these professionals that is rare, and even unrealistic, to expect that all skills will be developed or even present in any one individual. Ideally, Kilty suggests, it might be more beneficial to expect the complementary expertise of many different professionals to come together in a team setting.

Gronlund (cited in Wyman and Fernau, 1977) conceived the educational process in terms of five principles:

1) clearly defined domain of learning tasks,
2) clearly specified standards of performance,
3) adequate sampling of performance,
4) test item development on the basis of how well the specified behaviors reflect the learning objective, and
5) the development of a scoring and report system.

If these principles are followed in any professional endeavor in hopes to evaluate, the outcome should be a criterion referenced tool.

Brief (1979) suggests that managing employee behavior is a central function of administration and that an appraisal system will not only help Supervisors gain control over their subordinates' job behavior but will improve employee motivation. He does suggest, however, that the principle way to ensure a party will trust a performance appraisal system is to intimately involve that person in the development of the system.

Cummings and Schwab (1973) present numerous methods for developing a performance appraisal system. Burke and Goodale (1973) emphasized the determinants of employee behavior to be evaluated through the use of behaviorally anchored rating scales. All conclude that it does not matter how the evaluation is done as long as Supervisors and employees believe that the appraisal system provides realistic pictures of job performance and that the data derived from such appraisal are actually used to correct problems and reward employees for good performance (Brief, 1979:8).

Golightly (1979) used a management by objectives (MBO) approach to tap the resources of staff to diagnose and resolve a performance appraisal problem. The results-oriented approach of Ganong and Ganong (1974) was the product. Possibly the greatest outcome, however, of the process was the positive results gained by using staff as resource units and the level of acceptance gained. Havelock (1973) notes this process of gaining acceptance in greater detail.

Jones and Johnson (1979) differentiate between judgmental and developmental evaluation systems and suggest that it is not reasonable to expect one evaluation system to provide both types of data.

An interesting approach to evaluating health care services is outlined by Gilson et al (1975) with the Sickness Impact Profile (SIP). In reaction to the use of structure and process measures (because of the accountability of outcome measures), SIP offers a behavioral measure from the consumer of services which can reflect on the adequacy of programs and on the services offered.

As one can imagine from the descriptions offered, the methods employed in business and education have enjoyed ready, if not speculative, success within the nursing profession as a whole. Some of the methods, notably MBO and competency-based evaluation seem quite applicable to community health nursing.

Applicability of Methodology to Community Health

Traditionally in community health nursing where supervision is generally indirect and a great deal of independence is accorded the nurse in her duties, a management by objectives approach to evaluation has value. This allows the supervisor greater insight into the perceived strengths and weaknesses of the nurse involved without the requirement of prolonged observation of practice which is almost impossible in the extensive arena of community health practice (Harms, 1981).

Competency-based evaluation has similar problems in any nursing practice area. Spady (cited in Finch, 1980:398) notes the problems of basic definitions, conceptual clarity, and analysis of organizational and social implications of competency-based evaluation approaches. In community health nursing, where the practitioners, themselves, cannot agree on the definition of practice (Highriter, 1977), major work must be done before this method is feasible.

The Sickness Impact Profile has immediate applicability to the evaluation of health services and could be used to assess the appropriateness of programs and services to the community, thus fulfilling some of the philosophical problems of the community health focus on aggregate health. However, it has limited use when trying to assess the individual performances of professionals within the agency as a whole. The Scottish system of health visitation where one nurse is responsible for the total health of a given population rather than focusing on programs and segregated activities, would allow this system more validity in assessing individual nurse performance.

More methods are available from business and education that can be adapted or transferred directly to the community health area. It is perhaps comforting for nurses in the field to note practices elsewhere and benefit from the failings and successes before attempting to institute practices which seem initially to be appropriate and on target.

C. Competency Testing

A descriptive approach to nursing evaluation with some focus on the presence of competencies within the community health arena has been selected for this study. The issues and the literature on competency testing is presented as a means of indicating the appropriateness and the difficulties which such a focus will entail.

Competence

Competence has been defined by Schneider (1979:1) as "the quality or state of being functionally adequate or having sufficient knowledge, judgment, and/or strength." Britell (1980:24) suggests that a distinction must be made between competence and excellence in that competence contains reference to adequate performance of a task relative to the required performance and contains no inherent comparison to others' achievements. Excellence, contrastedly, refers to an absolute state of achievement and the highest level of performance attained by a few relative to the many.

Minimal competency and associated standards suggest an equality of competence. Kennedy (1980:197) vocalizes this dilemma: How can society (in this instance focused by the nursing associations), recognizing the variation among nurses, as well as the variation in society at large, reasonably satisfy its responsibility to assure universality of minimum competencies?

This perhaps brings up an important issue in competency testing. By focusing on safe practice standards and minimum competency levels necessary for those practices, is there not the possibility of promoting adequacy rather than excellence? This is not an unusual concern as noted by Baratz (1980:64) as he questions: What is a standard? What constitutes "mastery" or "satisfactory" performance? Will minimum standards turn into maximums?

Engle and Barkauskas (1979:10) define standards as "statements of excellence" while Britell (1980:24) suggests that standards represent the prespecified required level of activity rather than excellence. The importance of setting standards becomes paramount and increasing attention must be paid to the legal, technical, and political issues involved. The CNA (1980) and the AARN (1981) have both set standards for nursing practice to be used in any practice setting. Yet these delineated standards are not the same. What differences occur in definition? Why? Which should be followed? Which could best promote nursing excellence in preference to adequacy? How can these standards be translated into measurable behavioral items? These are all necessary concerns, yet none have been publically addressed by the nursing associations.

Competency Measurement

Tractenberg (1980:93) suggests in a review of Britell's minimum competency analysis, that broad choices exist for the measurement of competencies: (1) actual performance in the previous and subsequent job situations; (2) simulated performance in situations resembling those encountered on the job; (3) job performance at the time competency is to be measured; and (4) paper-and-pencil tests. Most methods to date have been designed for applicability to the student nurse rather than the graduate nurse in active practice.

In practical nursing, competency has traditionally been measured by task analysis. Performance of nurses in the achievement of selected tasks is observed and the ideal is described, analyzed, and noted in terms of its behavioral components. Instruments are then developed to measure the behavioral components, and applied to the nurse in active practice (Schneider, 1979).

This procedure appears on the surface straight-forward and while perhaps costly and time consuming, manageable. What then are the difficulties? In addition to cost and time, the following problems are cited by Schneider (1979:2) as being inherent in the evaluation of clinical performance: inconsistency between raters, low reliability of results obtained, defects in test validity, application of arbitrary standards, and weighting of some aspects of performance when such a practice may not be warranted.

In a survey of attempts at task competency testing (Urey, Dunn, Gorham, Zasowka, and Heins cited in Schneider, 1979:1-7), the following conclusion seems apparent although not literally stated: nursing is a complex art and cannot be analyzed into a manageable set of components that can be behaviorally monitored, and instrumentally measured with any acceptable level of validity and reliability.

What other alternatives exist for competency testing? Other methods have received some support in nursing competency testing. Films (Schneider, 1979) as a method of simulation, and paper-and-pencil tests (Britell, 1980) have been used , however, these methods again fail to assess the nature of nursing in a comprehensive manner. For selected task analysis and competency testing, they apppear to warrant consideration but do not seem appropriate for testing the general nature of nursing practice standards.

What then is left for consideration? Worthen and Sanders (1973) and Sanders (1980) suggest that the best way to select a method for testing follows a needs assessment. By specifying the exact nature and definition of that which is to be tested, methodology can be developed through time honored techniques. Without an adequate needs assessment, no one methodology can possibly hope to entertain the scope of evaluation required.

Competency Testing in Alberta

A successful example of competency assessment appears present in the Project for Administrative Skills and Knowledge developed by the Department of Educational Administration, Uiversity of Alberta with application made to school principals. Using a QAM (Quadrant Assessment Model) needs assessment procedure (Sanders, 1980) a set of skills was delineated, expressed behaviorally, and used self-assessment of performance to identify weak skill areas. Remediation programs are provided for the identified weaknesses. This project may provide some guidelines for nursing evaluation.

A recent study for nurses (Coldaway, 1981) developed some 1300 skill competencies for clinical nursing that appeared distinct yet not totally inclusive of all nursing standards. Other studies (Schneider, 1979:2-4) have focused on subsets of skills ranging from 5 to 345 in number. In discussing the applicability of task analysis competency evaluation for nurses in the light of these studies, Magnan (1981), Coldaway (1981), Lewchak (1981), and MacKay (1981) agreed that the problems with a competency evaluation tool for nursing was contingent upon the number of skills that could be delineated. The great number of skills required to define the nature of nursing made the procedures nonfeasible and limited their applicability to the evaluation of selected tasks only.

Both the CNA (1980) and the AARN (1981) have developed nursing standards over the past three years. These delineated standards are seen as applicable to any nursing service area with modifications made in the behavioral indicators for the selected service area.

The difficulty appears that broad standards can be developed but to be useful must be specific to the selected area and that techniques are not yet available for measuring the standards.

The AARN has issued a plan for competency evaluation (AARN 1981), and has received Association commitment to cooperate in the study for the next five years. While logical in its progression, the study has one major flaw: no conceptual framework based on a needs assessment or a pilot study has been included (Middleton, 1981). The study is a result of the provincial government and Association's proposal for evaluation rather than a response from the field for internal assessment. An assumption seems evident that all practice areas have the same standards for performance and the same requirements for competence.

Conceptual frameworks are a necessity for any evaluation endeavor. While components such as standards, tasks, and contexts can be developed, these are of no lasting relevance unless they can be fitted into an overall plan.

Spady (cited in Finch, 1980:398) calls for basic definitions, conceptual clarity, and analysis of organizational and social implications of various competency based evaluation approaches. There is a need to develop a universally acceptable (at least to the nursing profession) definition of competency, a best method of testing competency, and a proper set of criteria for distinguishing between competent and incompetent practitioners.

One method of defining community health might be the use of an occupational analysis. Hindes (1976:7) defines occupational analysis as:

> a process that examines an occupation and lists the various performance skills, and knowledge, which in total make up the occupation. Within this list there exists items that are most critical to the learning process as related to occupational performance.The analysis must identify these critical items.

In implementing an occupational analysis, Hindes recommends analyzing the competent workers' performance as a basis for developing all levels of training and education. The term *task analysis*, while used interchangeably, has been defined by Butler (1978:78) as a listing of "the behavioral characteristics of the job requirements." He suggests that the source for such listing as the sampling of on-the-job workers and warns against the use of supervisory and/or instructional personnel, textbooks, manuals, or course descriptions. Butler suggests supervisory personnel may be too far removed from the actual tasks to be performed and may emphasize the administrative detail or the overall product. While this fear is acknowledged, it is also noted that such occupational profile studies (Dawson, 1979), and investigations into the problems of staff evaluation (Sterling, 1977) suggest further study into these issues.

While many occupational analyses have relied on the technical performance of the individual (Schneider, 1979), Frycklund (1975:6) claims that the procedure of task analysis can be applied to all areas of work besides those of a strictly mechanical pursuit, as he states:

> whether there is a project, an idea, a bill of goods sold, a nursing assignment, a police assignment, standard elements are likely to be involved and there is something similar to a problem to be solved. The elements must be identified and listed because they are the things to be taught, not the problems.

In an attempt to clarify the concept of competence, Gale and Pol (1975:20) suggest that "no group can claim professional standing without explicit statements about what constitutes competence in that field and the means by which competence can be obtained and measured." This tying together of competencies and evaluation forms the emphasis of this study.

Issues to be resolved initially are: What is nursing? From whose viewpoint is competency to be assessed, the educators, the public, or the nurses themselves? What is the purpose of the evaluation? How will it be used? Why? Is it an end-stop or does the plan involve processes for remediation?

It is insufficient to consider only the "how" of competency testing. Jaegar and Tittle (1980) suggest that we must also ask why, when, for whom, to what ends, and with what eventualities. As nurses fight for a professional identity, they must define what nursing is – to themselves and to the public. To do this, they must have control over their practice – over the degree of competence ensured to the public and demanded from the public. Nursing competency with all its ramifications will certainly be a central issue in nursing in the 80s.

Summary

That nursing evaluation is of utmost concern is clearly evident in the amount of literature devoted to the subject in the past three years. Community health, as a subset of nursing practice, has not enjoyed the attention and specificity of methodology that hospital nursing has been accorded. However, the time for community health nursing evaluation is now, and the evaluation scheme proposed by the AARN (1981) has provided the impetus for examination into this practice area.

Many methods are available, each having some advantages over the other but each having some disadvantages. Some common findings from an examination of the literature include:

1) evaluation in nursing, regardless of the area of practice, is infantile in its development in comparison to other fields;
2) there is no one comprehensive evaluative method, therefore each method must be assessed in its applicability to, and the advantages and disadvantages of its use in the the particular setting and in the anticipated usage of its results;
3) community health nursing must define its practice before it can be evaluated;
4) any evaluative method must include those persons having a personal stake in the outcome if acceptance is to be gained for the final

performance evaluation system.

Community health nursing, as other nursing areas, is facing a complex task as it attempts to evaluate its services and its existence. Nursing is a complex art and its has been suggested that it cannot be analyzed into a manageable set of components that can be behaviorally monitored and instrumentally measured with any acceptable level of validity and reliability. Is this true? When nursing expands past the hospital arena and the traditional curative confines, the art and the definition of that art become even more complex. Regardless of its complexity, the problem of evaluation, however, remains and must be addressed now in the face of professional and public demands for accountability.

This literature review examined trends in nursing research with specific emphasis on methodology for evaluation. It was shown that there is currently a concern for the use of a wide range of approaches to nursing research. This review also suggests that a descriptive approach to the study of community health nursing may have some utility. Competency testing as a means of nursing evaluation has some drawbacks as an overall system of evaluation for nurses. It tends to focus on technical skills and minimum competence. However, as part of an overall study of the performance of community health nurses it allows:

1) an improved, more accurate, objectively based job description,
2) more objective measurable performance criteria, and
3) input from various sources which have a stake in the outcome of such evaluation.

These factors can make evaluation by competency investigation plausible and gives the study under discussion a place to begin the investigation into the broader complexities of nursing evaluation

III. THEORETICAL FRAMEWORK

The following concepts were utilized in the investigation and analysis of the problem: evaluation theory, change theory, political theory, and goal setting theory.

A. Evaluation Theory

Kellogg (cited in Sterling, 1977:11) states that the:

> essence of evaluation in the human and social sciences is that one human being makes a judgment about certain aspects of another human being according to some predetermined standard for some particular purpose.

Because this evaluation is based on value judgments, because each individual tends to perceive things uniquely, and because each individual has different values, it becomes very difficult to make an assessment that will be consistent with other evaluations.

Redfern (1976) corroborates this difficulty with value judgments in evaluations and concedes that the task of evaluation is not only difficult but almost impossible to fulfill. In an attempt to increase the plausibility of evaluations, several methods have been proposed.

Gephart (cited in Sterling, 1977), in a review of evaluation models, locates each model on a continuum. At one end, evaluation is equated with measurement such as the quantitative use of rating scales which associate an individual's performance with one of the labels on an arbitrary scale. On the other end, evaluation is equated with choice. The evaluator freely examines an issue of choice and concludes the worth of work that an individual has accomplished. Education, a discipline seemingly similar to nursing in its professional characteristics (Johnson, 1971; Cunningham, 1980), has been ascribed a central position on this continuum because of the service evaluation provides to the system's decision making process. Gephart suggests that "if the parties involved have different perceptions of the evaluative process, difficulties and disappointments can be expected." This insight might provide the rationale for including stakeholders in the formulation and implementation stages of any evaluative process. Such inclusion is supported by Brief (1979), Cummings and Schwab (1973), Golightly (1979), and Burke and Goodale (1973).

Evaluation Models

The necessity for a common perception of the evaluative process is important in identifying both the stakeholders and the process by which to formulate an overall plan. Evaluation models can help to clarify perceptions and to recognize the commonality of those perceptions.

Worthen and Sanders (1973:2) note that evaluation occurs in situations in which people make choices among alternatives, based on their perception of which alternative is best. They further suggest that the real worth of alternatives is determined on the basis of systematic efforts to define criteria and obtain accurate information about the alternatives.

This notation appears to describe the present situation in nursing and in particular community health. What remains as crucial is the determination of not only criteria and measurement techniques but also the determination of the perspectives of those having a stake in the outcome and the decision making for community health nurse evaluation.

Stufflebeam (1968) suggests that evaluation involves the four basic activities of decision making (goal choice), input evaluation (judgments of the strategies for goal achievement), process evaluation (strategy choice), and the final decision.

Stake (1967) defines antecedents, transactions, and outcomes from the vantage points of intentions, observations, standards, and judgments. Stake (n.d.:181) notes that:

> evaluation requires judgment. Decision making requires judgment. Both are judgmental in themselves but also depend on judgments previously made.

Stake further suggests that in order to understand what an organization is doing, one must understand what it is expected to do.

In applying the Stake "model" (Worthen and Sanders, 1973:21) to community health nursing in Alberta, one can identify the intents of practice (although not unanimously), and obtain observations regarding the performance of those intents. Until recently, no standards existed by which to judge these observations. The AARN and the CNA have now set such standards, but these have not been made specific to any nursing arena. It is therefore, important to determine if these standards accurately reflect the intents of community health nursing, can be readily observed, and if judgments made based on these standards denote the competency of the nurses involved.

Provus (1971) presents a discrepancy model whch compares standards to the actual performance of the individual and permits three alternative actions: performance change, standard change, and/or project termination.

Purposes for Evaluation

Enns (1966:23) stated:

> perceptions are not simple accurate reproductions of objective reality. Rather they are usually distorted, colored, incomplete and highly subjective versions of reality.

In this study, this perceptual limitation applies to the perceptions of nurses, Board Members and Nursing Supervisors toward the competencies required for staff nurses. The perceptions, as subjective as they might be, reveal the state of the art and the implications that has for the nursing profession.

Glass (1975) felt that evaluations, even with perceptive weaknesses, serve some purpose. Carvel (1972) suggests evaluation provides purpose for growth; a direction to pursue in order to satisfy individual objectives. Beall (1972) notes a stimulating effect on an individual when one's successes are recognized by the self and others. This effect is said to enhance the sense of personal growth and, possibly as a consequence of that, increase productivity.

Glass (1975) suggests that when an individual is evaluated, whether by self or by others, he experiences a fear that weaknesses will be revealed. Expanding on this fear of evaluation, Glass draws an analogy between the neurotic coping of an individual with the reality of weaknesses and an organization's coping with the threat of evaluation. Defense mechanisms abound in both – huge resources in time and money are profferred in role playing for an accreditation team or for a supervisor on location.

Houston and Hawsom (1972) notes the intermingling of evaluation data with judgments which tend to be punitive by nature. If the mind perceives evaluation as punitive, then the capacity to receive feedback that can redirect behavior is inhibited.

The conflicting expectations held by clients, professionals, Supervisors, and Board Members, make nursing evaluation complex. There is always a fear that evaluation will be unfair, that a true picture will not be presented, that insufficient data will be considered.

While applied to the teaching profession, the following quote by Carvel (1972:32) sums up the concern of most professionals over evaluation:

> . . . evaluation has been prostituted until it neither improves instruction (nursing) nor eliminates the incompetent. What it did with a high degree of success was harass both the evaluator and evaluatee into a mutual state of distrust. We can no longer afford to allow . . . evaluation to succumb to this trap

Community Health Nursing

As community health nursing gains more recognition as a nursing specialty, it becomes increasingly important that there be an analysis of the skills required by a nurse to function in the field of community health nursing.

A key component to consider when examining evaluation is the identification of criteria or competencies. The selection of criteria in evaluation constitutes a problem because of the complexities associated with determining common tasks and skills specific to community health nursing, and is accentuated by the human behavior variable of the occupation.

When discussing the creation of criteria for evaluation, Mitzel (1960:1482) notes:

> criteria cannot be trivial, otherwise evaluations are made against trivial standards. The problems of defining a satisfactory criterion and of locating or developing adequate measures of it have not been unique to . . . effectiveness research

Mitzel emphasizes that criteria selected should be characterized by relevance, reliability, freedom from bias, and practicality.

B. Change Theory

Chin and Benne (1969) note three strategies to use when implementing a change: empirical-rational, normative-reeducative, and power-coercive. These three strategies are outlined below:

Empirical-Rational

This strategy is based on the assumption that

1) man is rational;
2) once exposed to change which can be rationally justified and which will serve the self-interests of an individual or group, that individual or group will adopt the proposed change.

Fundamental, then, to this strategy, is the knowledge relevant to the object of change, and an understanding of the pattern of rationality which man exhibits.

Normative-Reeducative

The assumptions which underlie this strategy include:

1) man is inherently active, seeking impulse and satisfaction of his needs;
2) man's intelligence and actions are derived from influences of the larger society of which he is a member.

Changes involve not only the individual but his environment as well and the normative structures which define his relationship to that environment. Emphasis is placed on solving problems through the surfacing of attitudes, values, norms, and perceptions of the problem.

Power-Coercive

This strategy relies not on the use of power itself, but instead on the political and economic power that can effectively applied in the creation of change. Strategies can be non-violent, arise from poilitical institutions, and/or power-elite groups.

Havelock (1973) proposes several processes that lead to the diagnosis of a problem, through the choosing of solutions, to the gaining of acceptance. He notes six stages in the process of problem solving and change, including: establishing a relationship, diagnosing the problem, acquiring the resources, choosing the solutions, gaining acceptance, and evaluating the outcome through a process of self-renewal.

This study, in itself, represents an intervention into the change strategy assumed by the AARN in implementing an evaluation program which has been proposed from above rather than gaining impetus from the stakeholders and their perceived needs. It seems noteworthy, then, to document the events in this change process and reflect upon the influence a needs study and preparatory workup might have on the eventual implementation and acceptance of the evaluation program.

C. Political Theory

Politicized adaptation, according to Wiles (n.d.: 1) denotes a general change defined according to assumptions about the source of stress between maintenance of the present system and the need/demand for change policy options to effect specified changes, and the allocation of resources to promote a controlled change process toward the desired goal.

The study of evaluation implementation is investigated by discussing the particular system and adaptation when perceived as politicized phenomena, describe the macro policy system (those responsible for the preparation and function of community health nurses) under stress conditions and speculate upon the natural processes of adaptation which occur within this policy context.

Politics of evaluation can also be examined by investigating the interest aggregation and interest articulation (Almond and Powell, 1978) of the community health nursing associations: the Community Health Nursing Supervisors Society, and the Community Health Nurses Society.

Any optimism in competency evaluation is, according to Bardon and Robinette (1980: 159) based on the assumptions that criterion scores that make sense in the nursing perspective can be established, and that competency testing will not be abused through gross misunderstanding, used for unrelated purposes, or for unwanted social and political side effects.

It is these political effects from environmental constituencies that seem important and necessary to understand in investigating the perceptions toward an evaluation program for community health nurses.

D. Goal Setting Theory

Pincus (cited in Wiles, n.d.: 1) notes that in situations of unclear goals and objectives, the study of innovation by standard economic criteria is less realistic, taking the view that this type of influence is a "lubricant for bureaucratic and social pressures." He continues on to argue:

> if goals are in some (way) undefinable, it is inappropriate to adapt a standard rationalist approach of first defining goals, then seeking means to achieve ... it may be wiser to try out systematic innovation and assess their consequences.

How the goals for evaluation are set in the community health arena are unclear. How innovative programs should be implemented is equally unclear if one takes into account the potential for stakeholder acceptance and longterm success of the innovation. A study on the goal setting mechanisms in operation and their possible application to the problem at hand would seem beneficial.

E. The Concepts and the Alberta Scene

It is noted that there is considerable overlap in the conceptual frameworks by which the study is investigated and analyzed. These do not seem incompatible and could be viewed schematically.

The Community Health Nursing System

The health unit is viewed as a number of people or groups who are interrelated and interdependent trying to work together to achieve some common goals.

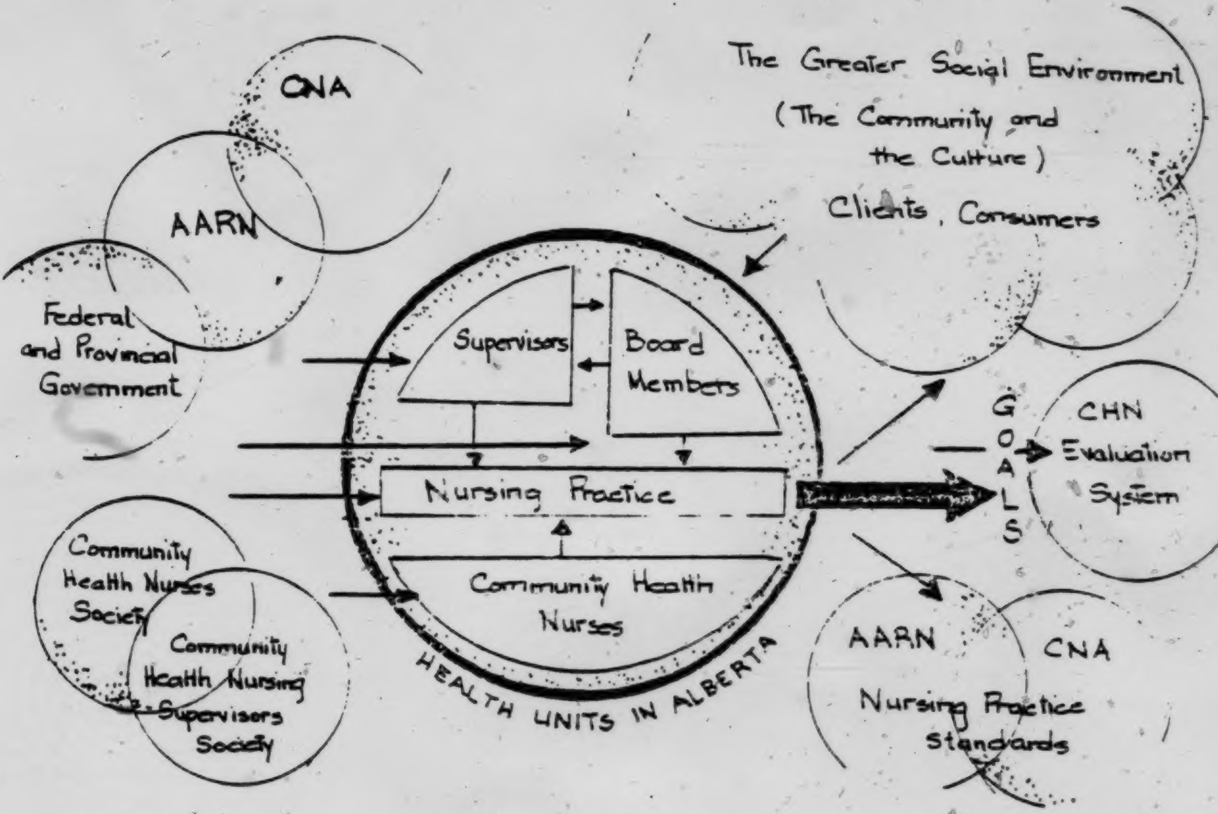
CNA
AARN
Federal and Provincial Government
The Greater Social Environment
(The Community and the Culture)
Clients, Consumers
Supervisors
Board Members
Nursing Practice
Community Health Nurses
HEALTH UNITS IN ALBERTA
GOALS
CHN Evaluation System
Community Health Nurses Society
Community Health Nursing Supervisors Society
AARN
CNA
Nursing Practice Standards

Figure 1: The Community Health Nursing System

– adapted from Havelock, 1973:67

Community health, in Alberta, operates out of health units throughout the province. Within each health unit, the practice of nursing as inferred by its programs and policies, is developed through the interaction of Board Members, Nursing Supervisors, and community health nurses. This inner circle is seen as having the greatest stake in the outcome of staff nurse evaluations.

The expectations of these groups, however, is a function of their experiences and their environment (physical, social, and political). This environment involves other stakeholders who have a more peripheral interest in the evaluation of community health nurses. These stakeholders include: professional societies and associations, governments, and health consumers.

The focus of this study will be on the perceptions of the inner core of stakeholders for it is believed that the perceptions of these group members will necessarily reflect some of those of the outer core.

Problem Solving Within the Community Health Nursing System

The problem of staff evaluation within the CHN system must be addressed in the same fashion as other problems through a problem solving technique; this can be viewed schematically as follows:

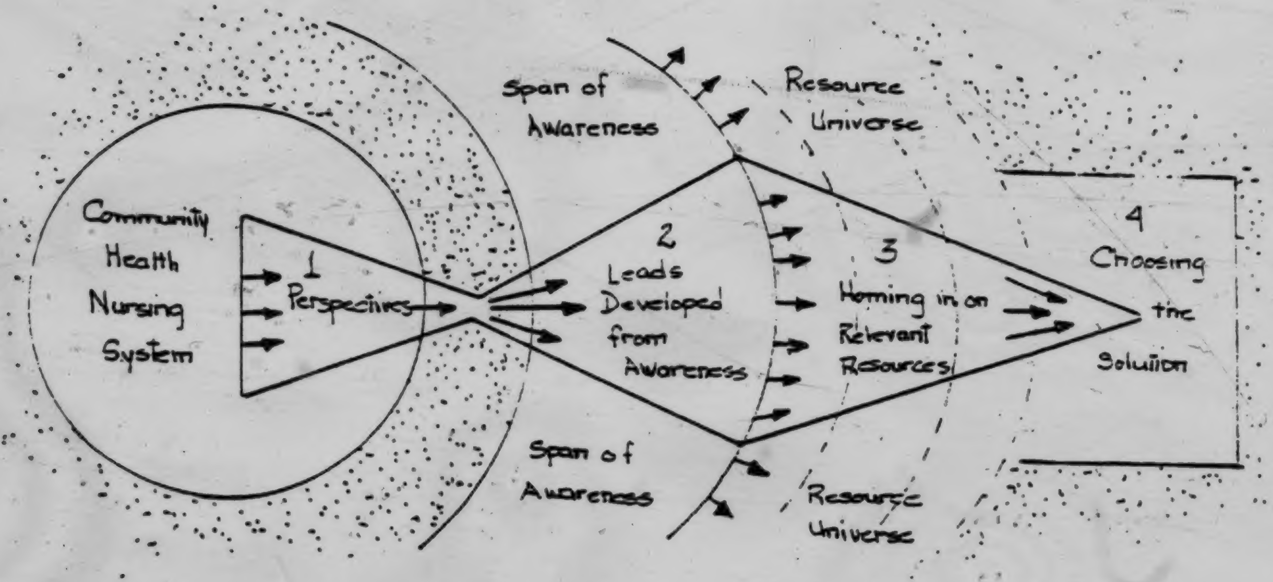
Community
Health
Nursing
System
1
Perspectives
Span of
Awareness
2
Leads
Developed
from
Awareness
Resource
Universe
3
Homing in on
Relevant
Resources
4
Choosing
the
Solution
Span of
Awareness
Resource
Universe

Figure 2: Problem Solving Within the CHN System

– adapted from Havelock, 1973:82

Figure 2 starts at the left where an attempt is made to attempt to identify the specific problems and/or conditions present in the system. These problems, once identified, feed into the awareness of the stakeholders and trigger connections with various resources. Once resources are identified, the system can home in, acquiring a range of solutions or relevant items which can be used in choosing the solution alternatives (Havelock, 1973).

The formulation and implementation of an evaluation procedure is recognized as a problem for community health nursing stakeholders. Four stages can be identified in problem solving and/or implementing change: identifying the client situation, increasing the stakeholder's span of awareness, identifying and securing the necessary resources, and choosing the solution or implementing the change. This study involved the first two stages. The first stage identified the community health nursing situation as it pertained to evaluation through an examination of stakeholder perceptions regarding CHN competencies and evaluation methodologies. The second stage was a byproduct of the study. By their involvement, stakeholders have been exposed to the issues and possible directions for CHN evaluation. Further awareness will be entertained on completion and dissemination of the study. Resources have not been fully identified and the solutions have not been chosen. The third and fourth stage are seen as in-house activities and will be focussed on as part of the overall change process.

Possible Impact of the Study on the Change Process

In order to address the problem of community health nurse evaluation, a change process must be involved. The community health nursing arena, in the form of health units within the province of Alberta, is viewed as the center of the change process. Within the community health system, the problem solving process has already been alluded to (Figure 2). This more generalized system must be also be examined to identify the possible effects of the study process and other potential change agents on community health evaluation.

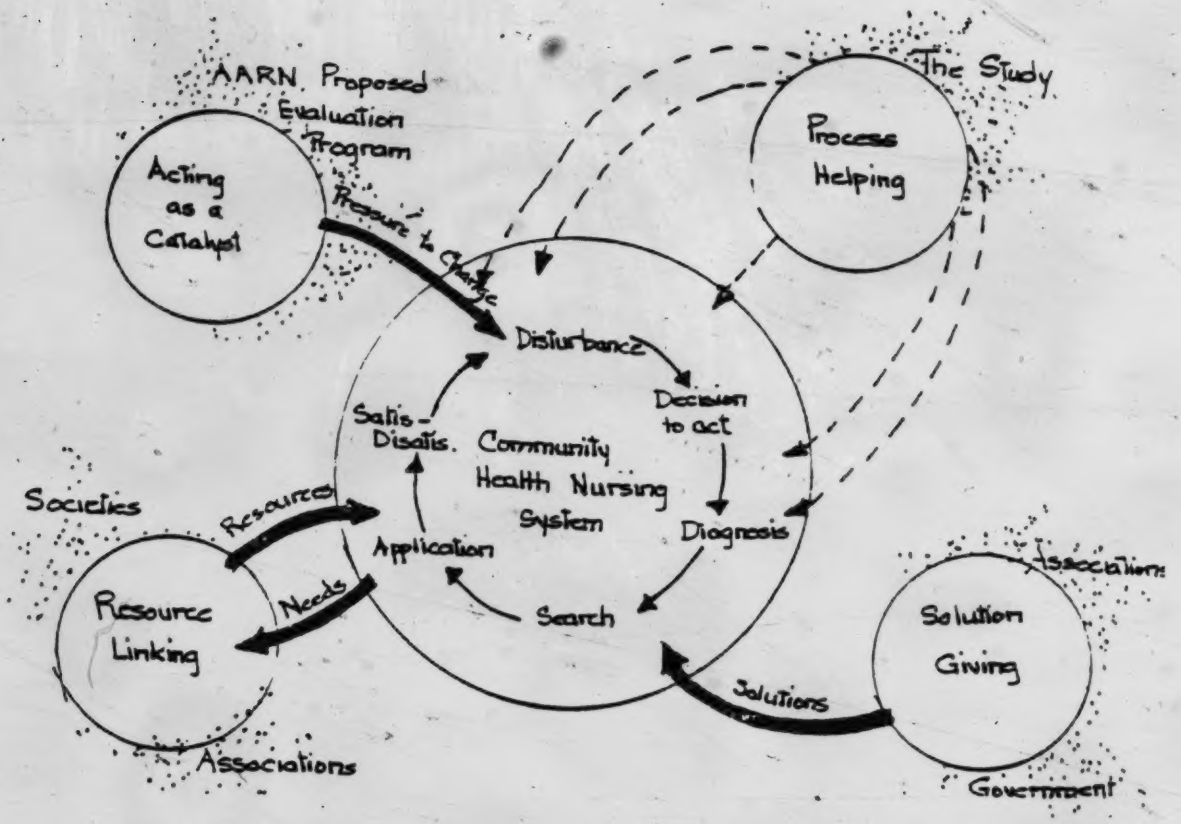
AARN Proposed Evaluation Program
The Study
Acting as a Catalyst
Pressure to Change
Process Helping
Disturbance
Decision to act
Satis- Disatis.
Community Health Nursing System
Diagnosis
Application
Search
Societies
Resources
Needs
Resource Linking
Associations
Solution Giving
Associations
Solutions
Government

Figure 3: Change and the CHN System

- adapted from Havelock, 1973:8

Four forces can be identified as having an impact on the direction of change that the system will eventually take; these include: acting as a catalyst, resource linkage, solution giving, and process helping.

Acting as a Catalyst

Havelock (1973:8) notes that "most of the time, most people do not want change; they want to keep things the way they are, even when outsiders know that change is required." At times, some outside force needs to overcome the inertia, to pressure the system to be less complacent and to start work on serious problems recognized by the system.

The AARN proposed evaluation program and its original timeline for fall 1981 to spring 1982 provided the impetus for immediate action. The growing concern about evaluation and the administration's focus on this issue in their inservice programs provided additional impetus but of a less vital and compelling nature.

Resource Linkage

Effective problem solving requires the matching up of needs and resources. Resources may include financial support, knowledge of solutions, knowledge of process, or people with the time, energy, and motivation to assist. The professional associations, and the members within those associations, provide resources for any change endeavor. Resource links within this context might include the Community Health Nurses Society, the Community Health Nursing Supervisors Society, and the Department of Social Services and Community Health.

Solution Giving

Many people have definite ideas about what solutions might be appropriate to the problems and feel that others should both agree with and adopt these ideas. The actual process and finesse with which these solutions must be presented to get implemented, however, makes this force complicated.

Solution giving, and the person or group providing those solutions, tends to be viewed negatively when located in a professional arena wishing a high degree of self determination. To limit such outside control, in-house activities are important. While the government and the union may be viewed as solution givers in this case, no active participation is presently noted.

Process Helping

By helping individuals or groups recognize and define needs, diagnose problems and set objectives, acquire resources, create and select possible solutions, adopt and install solutions, and evaluate the chosen solution based on the original need, process helpers will have an impact on the change process.

In this case, this process helping role could be filled by the researcher through the study process. Involvement in and the results achieved by this study could affect the change process and the eventual choice of CHN evaluation procedures by assisting in-house participants to examine the situation collectively and objectively.

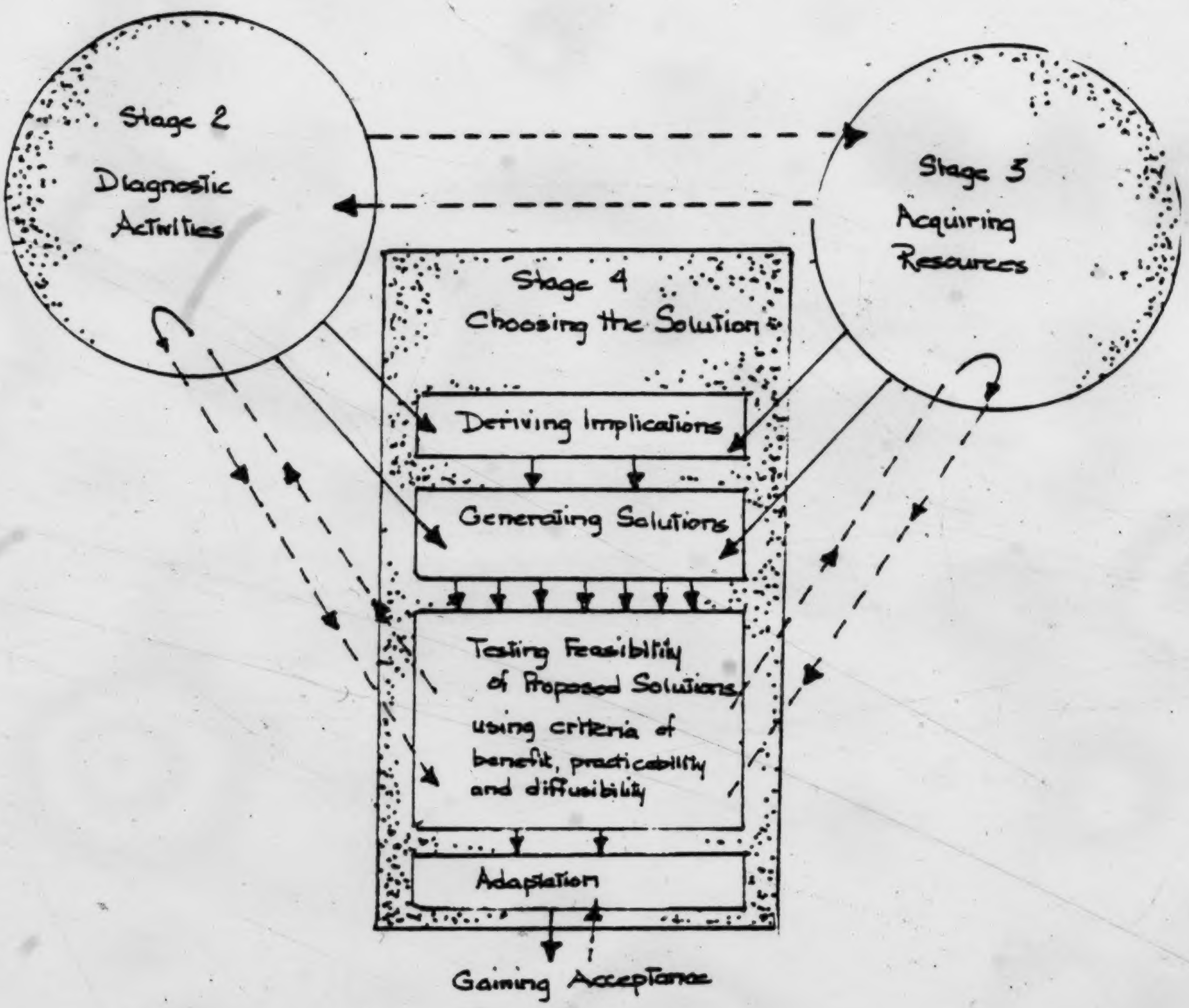
Stage 2
Diagnostic Activities
Stage 5
Acquiring Resources
Stage 4
Choosing the Solution
Deriving Implications
Generating Solutions
Testing Feasibility of Proposed Solutions using criteria of benefit, practicability and diffusibility
Adaptation
Gaining Acceptance

Figure 4: How Study Results Are To Be Used

- adapted from Havelock, 1973:99

The study was developed to provide results that could be utilized in the choice of a direction and/or solution to the problem of community health nurse evaluation. Perspectives of the stakeholders provide implications for future directions and can generate a range of solution ideas. The feasibility of these ideas must be examined within the community health system and in light of the constrictions within the professional and political arenas of that system. The goals set for evaluation are dependent on the process and the significance of that involvement experienced by the stakeholders.

F. Summary

A number of concepts were utilized in developing the conceptual framework. An application of evaluation models and theory provided a framework to view community health nursing evaluation attempts. Change theory, with an examination of the problem-solving process and of change implementation strategies, suggested a means by which to involve community health nursing stakeholders. Political theory and goal setting theory were examined in an attempt to increase the awareness of possible implications of community health nursing evaluation. The four concepts were viewed as interrelated and were presented schematically in an attempt to familiarize the reader with the community health nursing system as it existed in Alberta at the time of the study.

IV. METHODOLOGY

A. Introduction

The purpose of this study was to describe the community health nursing competencies from the perspectives of three select groups, Board Members, Nursing Supervisors, and community health staff nurses, and to examine the relationship between their perspectives and their performance evaluation programs. Literature related to the methodology is presented and the pilot study reviewed. The selection of the sample, data collection procedures, and the treatment of the data in rounds one and two are discussed.

B. Literature Related to the Methodology

The literature related to the methodology employed in this study will be discussed with emphasis placed on field studies, interviews, and questionnaire design. In round one, three methods of data collection were used: interviews, questionnaires and document review. In round two, two methods were employed: group interviews and questionnaires. Each required the development of appropriate instruments.

Field Studies

Field methods have been frequently employed in areas which attempt to identify practice situations. Zelditch (1962:569) states that such studies imply a

> commitment to a perspective in both the method of research and the handling of data in subsequent writings but it does not explicate the methods of doing either.

Zelditch suggests that field studies do not constitute "a single method gathering a single kind of information." Ianni (1979:377) notes that:

> those of us who propose the use of field methods in the study of . . . organizations start from the assumption that the test of the empirical world begins in the empirical world itself since operational reality exists there.

In discussing field studies, Kerlinger (1973:406) identifies the following strengths of the method: realism, significance, theory orientation, variable strength, and heuristic quality. Williamson, Karp and Dalphin (1977:209) emphasize the essential strength of allowing the researcher to continuously integrate the processes of data collection and analysis. Lutz and Iannaconne (1969:15) integrated the work of several authors and presented an extensive list of advantages, all of which may or may not be relevant to a particular study. Overall, the researcher when doing field studies can find a rationale for virtually any method he might feel applicable to the situation under study.

The use of field research techniques is particularly important as a means of establishing and continuously validating a theory of practice which informs both research and practice. While his comments were addressed to education, Ianni (1979:378) notes the importance of such research in an "applied professional field" and insists that such research provides at least a "potential for eventually making decisions by practitioners more informed." The application of these statements to nursing seems immediately relevant. One can assume nursing to be a unique and complex field which cannot be studied only as an analogue of business, industry, government, or education. The uniqueness of its social actions can be identified and subjected to observations and analysis with as much vigor as these other fields. Ianni (1979:379) suggests that such field complexity implies that

> no single research style, no solutions borrowed from other professional areas, nor any revolutionary new theories from the social or behavioral sciences are going to supply definitive answers to the problems of practice.

Nurses must first understand their own social field.

Such views allow field researchers to be methodological pragmatists, to see each method's capabilities and limitations, and to learn through on-site experience which methods obtain adequate answers to posed questions. While this approach may seem to give the impression of a lack of rigor, Ianni (1979) cautions that methods are, after all, merely instruments designed to identify and analyze the empirical world and as such, their value exists only in their suitability to that task.

Interviews

Interviews were used as a method of data collection throughout the first round with Supervisors, and then sporadically among the nurses and Board Members as a comparative measure. Group interviews were employed in the second round as a means of validating the findings of round one.

The interview as a research instrument has several advantages (Murphy, 1980; Institute for Social Science, 1969):

1) it can obtain information that would be missing with the use of

impersonal methods;

2) it can supplement respondent answers to questions with observations of body language and make inferences as to the comfort of the respondent with the topic under discussion;
3) it can obtain spontaneous reactions to the questions as opposed to measured responses;and
4) it can clarify responses and correct misunderstandings of the question intent.

However interviews are only as effective as the interviewer. Care must be taken that the interviewer presents an understanding profile and is capable of accepting what the respondent says without apparent judgment and/or personal rejection of the respondent. The intent of the interview must be clear. The respondent needs to see the survey as important and worthwhile. Barriers need to be overcome. The interviewer should specify the purpose of the study, the selection of respondents, confidentiality of the interview, and the beneficial uses of the research findings (Institute for Social Science, 1969:2-4).

Bradburn and Sudman (1980:x) identify three conceptually distinct causes of response effects in any given situation variables derived from:

1) the nature and structure of the task;
2) the characteristics of the interviewer; and
3) the characteristics of the respondents.

The Nature and Structure of the Task

Bradburn and Sudman (1980) consider the issue of threatening questions and/or subject matter. The threat may be real or imagined and depends upon the perspectives of the individual respondent. These authors suggest that no data collection method is superior to all other methods for all types of threatening questions; each data gathering technique must be assessed as to the situation in which it is meant to apply.

Bradburn and Sudman (1980:14) note that question threat is mediated by several variables, particularly question structure and length. They conclude that:

1) question structure and length do not affect response effects for non-threatening questions;

2) for threatening questions, closed-ended questions elicited negative response effects and seemed more sensitive to social desirability factors. Open-ended questions were thus seen as more appropriate for threatening topics.

3) response effects for threatening items decrease with increasing question length and thus longer questions may be most appropriate for threatening topics.

What remains an issue is the threatening nature of the topic to be studied. Is evaluation a threat? Is the task of generating competencies a threat? Is fear of embarrassment due to lack of knowledge in these areas a threat? Again, threat will be determined by the individual. To reduce possible occurrences, however, the following features were incorporated into the instrument design:

1) more than one method of data collection was employed;
2) open-ended questions were used;
3) longer questions and elaborations were provided;

Characteristics of the Interviewer

Interviewer effects occur through non-programmed interviewer behaviors. Bradburn and Sudman (1980:26) cite Hyman et al (1954) as postulating that interviewer-expectation effects are actualized by:

1) means of probes which may lead respondents;
2) failures to probe where answers are uncertain; the interviewer may then record what he thought the respondent intended to say rather than what was said or implied;
3) errors in recording;
4) communication through feedback of interviewer expectations; and
5) other more subtle behaviors.

In a study designed to determine interviewer effects, Bradburn and Sudman (1980:28) conclude that respondents who refused taping, respondents who did not refuse taping but were not taped, and and respondents who were taped, were virtually identical in their responses. Non-programned speech behaviors did not affect the data. Thus taping and inadvertent speech behaviors were non-issues.

Expectations about a study may be formed before or after entering the field. However, Bradburn and Sudman (1980:52) suggest these variables to be much less powerful than task variables and suggest they be accorded less priority in the examination of response effects.

The chance of interviewer effects in any study is real and the pilot was designed to address these concerns.

Characteristics of the Respondents

Bradburn and Sudman (1980:130) describe the anxiety respondents feel when asked a threatening question. The authors conclude that respondents who feel uneasy about a topic are less likely to respond accurately. The respondent's need to convey a particular image to the interviewer may distort survey data. Assuring respondents of absolute confidentiality has a small but significant and consistent effect on the respondent's willingness to answer questions. Providing more detailed, informative, and truthful introductions to studies was shown to affect neither the overall response rate nor responses to individual questions (Bradburn and Sudman, 1980:132).

Interviewing in the Presence of Others

Group interviews were used as a method of data collection in the second round. Additional concerns must be addressed with the presence of additional persons in the interview situation, whether they respond or observe.

In a study assessing the effect of third parties on survey data, Bradburn and Sudman (1980:146) suggest that data are immune to the presence of additional respondents. To increase the amount and ease of reporting behaviors in group situations, Bradburn and Sudman (1980:167) suggest:

1) using a long introduction to the question topic;
2) leaving the answer format open; and
3) letting respondents pick their own words.

Face-to-face interviews, involving personal interaction between interviewers and respondents, however, are thought to be potentially more open to bias than more impersonal methods such as questionnaires. Method selection, as a result, will be more influenced by other considerations such as cost, access to the sample, and ease of administration. These features were built into the instrument design.

Overall

Interviews provide a wealth of data. Because of the three issues discussed – threatening questions, interviewer effects, and respondents effects – structured interviews were seen to be potentially more advantageous.

Murphy (1980) and Johnson and Smith (1975:207) have listed benefits of a structured interview. Those applicable to this study include:

1) the questions are based on the research objectives of the study; the more structured the measurements the more clarity may be given to a particular theory and/or issue.
2) respondent interest can be established early;
3) the interviews can be standardized and the results made comparative;

Several *how-to* manuals have been written on the interview (Institute for Social Science, 1969; Murphy, 1980). Steps to ensure reliability and validity of the procedure are presented and encouraged. These have been undertaken in the pilot study and will be discussed in combination with questionnaires.

Questionnaires

Round one involved the completion of questionnaires by as many of the community health staff nurses, and Board Members as possible during the period of June through October 1981. Second round participants were offered the alternative of reacting to the first round findings in a questionnaire format in preference to an interview situation.

Several studies have used a survey approach in defining and generating competencies and in gaining the perceptions of evaluation methodology. Sterling (1977) investigated principal and superintendent perceptions of evaluation through the use of prespecified criteria, personnel, and methodology in an attempt to gauge reactions of these respondents to the present programs of evaluation being used.

Those issues discussed relating to interviews can equally be applied to the design and use of questionnaire instruments.

Nature and Structure of the Task

Bradburn and Sudman (1980:12) suggest that self-administered procedures are slightly better than other methods for reducing overstatements on questions about performance of "socially desirable acts" but worse on questions about "undesirable acts." The cooperation and/or response rate, however, is lowest for self-administered questionnaires.

Requirements for question structure and length apply whether used in interviews or questionnaires and therefore similar practices were followed when questionnaires were developed from the interview schedule.

Questionnaires are less costly and time consuming than interviews or direct observation, when the sample is large or distributed over a wide geographic area. They have the added potential benefit for complete respondent anonymity. These advantages seemed appropriate in this study in view of the large numbers of community health nurses to be surveyed over the province and the added anonymity for small numbers, as evidenced in the Board Member sample. Interviews are advantageous when questions are of a personal (perceptual) or sensitive (knowledge level) nature.

Characteristics of the Interviewer

Polit and Hungler (1978:351) note that because the researcher is not present during the completion of a mailed questionnaire, the possibility of researcher bias is eliminated. However, Kerlinger (1964:397) cautions the use of questionnaires because of the problems of low response rates and the inability of the researcher to check or elaborate upon responses made.

Characteristics of the Respondents

The potential respondent effects noted in the discussion on interviews are reduced because of the anonymity that respondents enjoy. Expectations for the study and perceived threat of the topic remains but to a lesser degree. The necessity of ensuring confidentiality in questionnaire surveys is supported by Bradburn and Sudman (1980), Davis (1980) and Murphy (1980).

The questionnaire method was used for this study because of its advantages and the difficulties experienced by the researcher in scheduling interviews with busy people over a widely dispersed area. Efforts were made to increase the response rate by negotiating entry and participation in the study through the Nursing Supervisor of each health unit. A pilot study which allowed comparisons between the interview and questionnaire as to the richness of the data collected was completed to check responses of the respondents and refine the questionnaire to minimize possible misunderstandings.

The questionnaire format was developed with consideration given to the group being addressed (Appendix H; I) and questions derived directly from the interview schedule (Appendix B). The questionnaire was divided into two components: one dealing with the generation and discussion of staff nursing competencies and the second part dealing with nursing evaluation methods. All questions were open ended to encourage creative thought and to gain personal perceptions rather than reaction to a preconceived competency listing.

Document Review

The formal documents on evaluation procedures employed by each health unit in round one were examined to ascertain commonalities and differences. Such written materials were used to support and check data collected from interviews and questionnaires.

Murphy (1980:121) contends that written materials provide reliable sources of detail. Documents, however, must be examined as only representative of the truth; they are open to distortion, bias, and omission. They do represent, in the case of the health units, what the agency wishes to set down in print. As such they present another method for triangulation of data.

Reliability and Validity

In considering reliability and validity of the study, the researcher recognized Lutz and Iannaconne's (1969:124) argument that, in observational research, reliable data ordinarily are valid. Additional measures were taken to enhance the reliability and validity of the study and included:

1) structured data collection methods using established recording and coding procedures were used to provide the first measure of reliability;
2) structured group interviews to solicit respondent's perceptions were designed to attempt to validate the researcher's perceptions of the data gathered in the first round;
3) pilot observations using videotapes, audiotapes and questionnaires were used to test and refine the skills and techniques required by the researcher during the conduct of the study;

4) operational definitions for all terminology were provided to the respondents to clarify the intent of the study; and

5) while inter-rater reliability was not a concern as the research was an independent endeavor, every effort was made to provide intra-rater reliability by eliminating personal bias and maximizing objectivity.

The researcher was able to utilize frequent opportunities to validate perceptions and impressions with the respondents to limit possible bias. Additional efforts included:

1) the provision of a detailed description of the project in advance of the respondents' consent to participate;
2) protection of the anonymity of the respondents;
3) briefing each respondent at the beginning of the interview in order to maintain continued understanding of the study;
4) maintenance of a non-judgmental presence;
5) use of a candid, cooperative, and amenable approach with each respondent; and
6) use of several items of evidence with a range of collection procedures.

C. Pilot Study

There are many aspects of a descriptive survey in which a rational decision can only be made if a pilot study is conducted prior to the main study, particularly in the event that no previous literature review and/or study has been done in the study area.

During the month of June and July, a pilot study was conducted. The purposes of the pilot study were:

1) to evaluate the interview methodology;
2) to gauge the reaction of the three groups to being included in such a study, i.e., the appropriateness of sample;
3) to test the feasibility of the interviewer role and the proposed data gathering techniques; and
4) to gauge the approximate time, finances, and data collection technologies required for the actual study.

An evaluation of the interview methodology to be used in the larger study was considered necessary to ensure that the intent of the study was being met, i.e., to gain the perspectives of the three identified stakeholder groups as to:

1) community health nurse competencies – present and ideal;
2) methodologies of evaluation – used and desired;
3) criteria for measurement; and
4) priorities of importance.

The purpose of the evaluation of the interview methodology was to establish the validity and reliability of the interview schedule and to establish the validity and reliability of the interviewer.

The evaluation team was composed of three members with varying experiences in community health nursing, survey research, and descriptive studies (Appendix E). The nurse member was able to indicate the practical significance of the study to the field and controlled the focus of the evaluative efforts through the ownership of the larger study. The non-nurse members were chosen to provide outside input into the nursing study as a means to limit bias. Because of the research and evaluation experience of these members, their perspectives and input to the study were considered invaluable.

Evaluation Questions

The purposes of the pilot were accomplished by attending to the following questions:

1) Was the interview schedule valid and reliable?
    a) Was a particular viewpoint or bias established or suggested in the question design?
    b) Were the questions fair, neutral, and understandable?
    c) Did different groups interpret the questions in the same way?
        i) Did the stakeholder groups interpret similarly?
        ii) Did the peer groups interpret similarly?
        iii) Did the members of the evaluative team interpret similarly?
    d) Did background/experience affect the interpretation?
    e) How ample was the coverage of study issues?
2) Was the interviewer trustworthy?
    a) Did the interviewer influence or bias the responses?

  - b) Did the interviewer suggest a particular viewpoint?
  - c) Did the interviewer appear fair, neutral, and understandable?
  - d) Were the analyses justifiable?
  - e) Were the records clear and valid?

3) Were the respondents honest?
  - a) Did the respondents give honest, complete answers?
  - b) Were claims of ignorance, uncertainty or refusals to answer allowed or encouraged?
  - c) Were answers unambiguous, frank, and credible?

Data Sources

Sample

A representative sample of the rural community health stakeholder population was selected on an availability and voluntary cooperation basis. These respondents could be included and/or removed from the larger study without disturbing the overall results. The sample was selected and arranged as follows:

1) one member from each of the three identified stakeholder groups interviewed by member A;
2) one additional member from the community health staff nurse category interviewed by member B to assess inter rater reliability;
3) one additional member from the community health staff nurse category to be given the questions three days in advance of the actual interview; and
4) one nursing professional to evaluate interview questions.

Instruments

The instruments used in the pilot are provided in Appendix A and C and included the interview schedule and a respondent questionnaire to assess issues of reliability, objectivity, and validity.

Data

The actual data collected included:

1) hand coded records of the interviews;
2) audiotape recordings of the interviews;

3) videotape recordings of the training interview; and
4) questionnaire responses;

Procedures

The procedures followed are listed in order of their occurrence:

1) Ed. Admin. 515 (Project Evaluation Course) students, University of Alberta reacted to study instruments;
2) validity of interview questions was established by having them evaluated by a nursing professional;
3) objectivity of interviewer was established through training procedures utilizing a videotape recording.
4) interviewer A completed interviews with sample from the three stakeholder categories;
5) interviewer B interviewed one additional member from the nurse category;
6) interviewer A completed interview with nurse having the questions in advance;
7) data collected by the two interviewers were compared;
8) each respondent evaluated the questions and the interviewer through the use of the respondent questionnaire;
9) nursing professional reviewed the audiotape of the interview to assess the honesty and representativeness of the answers;
10) hand coded records of the interviewer were compared with the audiotape recordings to assess how well the responses were interpreted;
11) each respondent checked the hand coded notes at the end of the interview to assess whether or not they represented the meaning that was intended;
12) data were analyzed and the results of the pilot study were interpreted.

Comments on Instruments

Twelve graduate students reviewed the interview question format and the respondent questionnaire used in the pilot study. From their comments, the following changes were made prior to using the structured interview format

1) definitions of key terms were presented to the respondents at the beginning of the interview to ensure common understanding of the interview questions;
2) questions were restructured for ease of understanding and placed in order of logical thought progression; and
3) additional questions were added to describe present methods of evaluation used in each health unit;

Comments on Interviewer Objectivity

A videotape was made and preserved of the interviewer in a role play situation of the proposed interviews. Special attention was paid to the verbal and non-verbal communication of the interviewer with the respondent when reviewed by the evaluation team and a selected nursing professional. No obvious bias was noted.

Tape Recording

All participants showed initial reluctance to the recording procedure but agreed to the taping once they were assured that the tapes would be used by the researcher only and that they as individuals and as a health unit would not be identified in the study. A small recorder was used to limit the intrusive nature of the procedure.

D. Health Unit Pilot

Negotiating Entry

A discussion was held with the Nursing Supervisor from a rural health unit regarding her participation in the pilot study. The reception of the researcher was positive and suggested that there would be no problems with entry into the larger study sample.

Analysis of Data

A total of 26 "competencies" were generated by the pilot sample and are presented in Table 1. Competencies are listed according to the frequency of reporting by respondents.

All five respondents were able to address each question as presented. The nurses presented 12, 6 and 10 responses respectively for an average of 9.33 responses to the

TABLE 1

PILOT INTERVIEW RESULTS

	Nurses	Supervisor	Board Member
Belief in preventive care	2	1	1
Basic nursing education	3	1	0
Ability to initiate care	0	1	0
Driving skills	1	0	0
Teaching skills	2	0	0
Evaluation skills	2	1	0
Counselling skills	1	0	0
Public relations skills	0	1	1
Communications skills	1	1	0
Assessment skills	2	1	0
Organizational skills	2	0	0
Inquisitiveness	0	1	0
Empathetic	1	0	0
Flexibility, adaptability	0	1	0
Resourcefulness	0	1	0
Versatility	1	0	0
Acceptance of all types of people	0	1	0
Knowledge of communicable diseases	1	0	1
Knowledge of occupational health	1	0	0
Knowledge of growth and development	2	1	0
Knowledge of mental health	1	0	0
Knowledge of agency structure	1	0	0
Knowledge of community agencies	3	1	1
Ability to work with other professionals	1	0	1
Ability to maintain competence	1	1	0
Ability to work independently	1	1	0

question on community health nurse competencies. The supervisor presented 14 responses and the board member 6. All five respondents felt the question on competencies to be appropriate and felt capable of presenting answers to that question.

Respondents were able to rank the "competencies" in some order of importance but four made qualifying comments that all items listed must be present for the nurse to be successful in her position. No consistency was achieved among respondents in this ranking. There was a tendency among all respondents to provide methods of evaluation rather than criteria for measurement for each of the "competencies" generated. When this was brought to their attention, some improvement was noted, but this appeared to be the most difficult section of the interview as judged from the comments of the respondents.

Four of the respondents noted some differences for nurses not working in community health; one felt there were no differences in competencies required of nurses working in different areas.

The evaluation method used in the health unit was presented and described in detail by the Nursing Supervisor. All other respondents described a method of evaluation that they had been exposed to or felt was being used. There was some variation in methods described but qualifying comments were added that a "new form of evaluation was being phased in and therefore that method had been used with new staff only." The rating given the present system of evaluation ranged from a score of 1 to a score of 4 on a scale of 1 to 5 , 1 indicative of high dissatisfaction, 5 indicative of high satisfaction. Reasons for judgments were provided.

All five respondents gave choices for the ideal evaluation. No one method was selected.

Respondent Questionnaire Results

The following results were obtained using the respondent questionnaire (Appendix C) and are presented in Table 2. A score of 2.5 or less was preset as a standard of acceptability. All scores fall within the acceptable range. The reliability and validity of the survey instrument was therefore considered acceptable. The interviewer was judged trustworthy, and the respondents honest.

TABLE 2

RESPONDENT QUESTIONNAIRE RESULTS

	Questions	Score
Validity	1,8	2.3
Respondent Honesty	2,6	1.5
Question Bias	3,10	1.4
Interviewer Bias	4,7	1.4
Validity (Topic Coverage)	5,9	1.9

Comments on the Interview Schedule

The following comments were made by the respondents following the interview about the question format:

those who did not receive the questions in advance:

> ...it would be helpful to have the questions ahead of time, then I could think about it (the questions) more

> ...I like to write things down and then think about them; but I think I gave all the answers I would have come up with

> ...I liked coming in unprepared – I think spontaneous answers are more truthful.

> ... its (the interview) made me think about the topic. I didn't think I would be able to answer the questions but I guess I've always known what a good community health nurse should be like. We probably all have ideas in that direction.

those who received the questions in advance:

> ...I found I kept thinking about the questions and then kept changing the answers. I think I might have been better off with my first ideas.

There appeared to be no one method of preparation that was more desirable. The results achieved were similar in the richness of the data obtained.

Review of the Data Collection Procedures

From review of the tapes and hand written records of the interview, there appeared to be no essential differences in the data obtained. The hand written records of the interview, when compared to the audiotape recording, showed no deletion of essential comments. There were no differences in the type and quality of information obtained by Interviewer A and Interviewer B.

Conclusions of the Pilot Study

The following recommendations and/or conclusions were made following the pilot study:

1) the study, content area, and expectations should be explained in advance of the interview to allow preparation for those individuals desiring such (Appendix F, G);
2) definitions of essential terms should be provided in written form to the respondents (Appendix H, I);
3) the questions used appeared to cover the intended study area;
4) hand written records, when subjected to respondent censure during the interview session, accurately reflected respondent's comments;
5) all three sample groups felt able to answer the questions, expressed appropriateness of the study, and of their inclusion in such a study.
6) the interviewer was judged trustworthy;
7) the respondents were judged honest;
8) the instrument was judged reliable and valid.

E. The Study

Selection of the Study Sample

The respondents of this study were identified through discussion with population members using a referential technique and personal field experience. Discussions were planned with formalized groups representative of the population. To gain confirmation of participation by their members, these groups included:

1) Community Health Nurses Society;
2) Community Health Nursing Supervisors Society;
3) Research Committees where present for the individual health units

All the above were contacted, some by telephone, some in person, and others by mail. In order to negotiate entry into the study population for both the pilot and the overall study, the following procedures were performed:

1) informal discussions were held with population members in random nature to gauge interest in the study, perceived relevance of the topic,

and the feasibility of their participation in the study;

2) formal application was made to the research committees to gain entry for both the pilot and/or larger study;

3) in person discussions/conversations were held with representative formalized groups to discuss the proposal, to gain cooperation, and to schedule on-site visits;

4) informal conversations were held with AARN Evaluation Program members to assure time allottment to this forerunner study in view of the provincial evaluation program.

Round One

Selection of the Sample

The sample for round one consisted of eleven health units and five health centers. Participation was extended to Nursing Supervisors, Board Members, and community health nurses from each health unit on a voluntary basis. The health units were assigned north, central, or south geographic status and numbered. The list was given to an independent researcher who randomly chose numbers from this list to divide the potential health unit population into two samples. The researcher reviewed this list and considered rural/urban characteristics. Upon decision that a reasonable match of the two samples had been achieved, contact was initiated with those health units assigned to round one. Contact was made through the Nursing Supervisor of each health unit by telephone and/or personal contact (Appendix F).

Data Collection Procedures

A preliminary examination as to the significance of the study topic and the feasibility of the research approach was completed during the period of January to May 1981. A discussion was held with Sellers (1981) and the time schedule for the study set.

Contact was made with the Department of Social Services and Community Health in June 1981 with the plan of presenting the proposal to the Community Health Nursing Supervisors Society. While direct contact was not achieved, acknowledgement of the study was gained. A suggestion was made that because of the summer schedule, the researcher should contact each of the Nursing Supervisors directly regarding participation in the study. A list of names and addresses of Supervisors and their corresponding health units was provided to the researcher. A copy of the proposal was forwarded to the Department for information purposes.

An initial interview was held with the Nursing Supervisor of each health unit, (Appendix B), and then participation was requested from the Board Members and staff nurses of that health unit. Questionnaires were distributed through the Nursing Supervisor or in some cases through the Local Health Authority Boards to individual members (Appendix H,I). Questionnaires were returned to the health unit in question and then forwarded en masse to the researcher. This was done to accommodate the 1981 mail strike rather than as a study procedure. Returns remained anonymous unless the respondents wished to identify themselves. No record was kept of identification when provided.

Followup was completed by telephone where required because of a mail strike. Letters, (Appendix G), were sent to additional Board Members in October 1981 to increase the sample in reaction to a small response rate. Notation of reasons for non-participation was recorded.

Because participation was voluntary and open to as many persons as available from each sample grouping, percentage rate of return was not preset to any required level. However, the following numbers participated in the first round, Nursing Supervisors 16 (100%), Board Members 8 (36%) and staff nurses 110 (no calculation of percentage, but varied from no participation to 95% in a particular health unit). The percentage of Board Members participating in the study is small. When approached regarding that participation, Boards indicated that they did not feel "knowledgeable in the area", and "preferred not to be involved in studies." Those participating in the study showed initial hesitation but stated that "the study seemed worthwhile" and that it was "something they could learn from."

Following the pilot study, due to respondent availability, the unexpected mail strike, and the difficulty in arranging interview appointments, variations in the data collection techniques were considered necessary. Because of the transfer to a written questionnaire survey for the majority of the respondents, an additional pilot was held in July. Twenty-two nurses, and two Board Members were interviewed using the questionnaire format to ascertain:

1) the comprehension of key terms;
2) the logical sequencing of questions;
3) the need for further explanation; and
4) the comparable richness of the data obtained.

Entry continued to be negotiated through the Nursing Supervisor of each health unit selected for the first round. Board Members were interviewed and recorded as available but were provided the additional option of responding to a written questionnaire (Appendix H). Nursing Supervisors were interviewed and recorded, and were used to negotiate participation on a voluntary basis, through the use of a written questionnaire (Appendix I), of community health staff nurses under their jurisdiction.

Data received through mail response and from these interviews were then reviewed by the researcher. No essential differences were noted in the richness of the data obtained. No major alterations were required in the questionnaire format.

Because of the adaptations required as noted in the pilot study, several forms of data collection were utilized in the initial round. These included:

1) recorded interviews. Only two interviewed subjects objected to the taping procedure (and therefore were not taped); hand written records verified by the respondents were used in all cases. Semi-structured interviews were employed using open-ended questions allowing for researcher probing where considered valuable and productive;
2) written questionnaires specific to the positions of community health staff nurses and Local Health Authority Board Members;
3) structured interviews using the written questionnaire format;
4) review of written evaluation procedures used in each health unit as provided by the Nursing Supervisor.

Selected interviews were transcribed by the the researcher and comparisons made with recorded notes previously verified by the interviewee. All hand recordings were compared to the tape recordings prior to analysis for final verification.

In the interview, and prior to the questionnnaire requests, the respondents were assured that the data would remain confidential and while excerpts of conversation might be used in the presentation of the data, no names and/or health units would be divulged.

More than one approach to data collection was used to help confirm the validity of the information gained.

Treatment of the Data

Content analysis was used for the treatment of data in both rounds.

Content Analysis

The purposes of this study were seen as best served by the use of content analysis. Deese (cited in Stone, Dunphy, Smith and Olgilvie, 1966:39) states:

> the primary objective in any content analysis is to provide some interpretation of a cultural product of possible symbolic significance. When the cultural product is linguistic, the usual form of the interpretation is a paraphrase. The paraphrase resulting from content analysis usually has two characteristics:
> 1) it produces propositions capable of being subjected to statistical treatment; and
> 2) it generally reflects some special purpose.

Deese continues on to state that content analysis does not try to discuss all of the possible themes in some product, but only some portion of them, that portion being determined by the social aims of the investigation.

The researcher recognized that themes were developed *a priori* for this study in that the interview schedule was designed to stimulate thought in selected areas, namely community health nursing competencies and evaluation methodologies. Categories within these areas of investigation were not developed until after the first round occurred and therefore represent *a posteriori* category development.

The design of the interview schedule and the constructs within it necessarily relied on information about the structure of the source or the population. Analytical success was seen as a function of the quantity of structural information available to the analyst (Krippendorf, cited in Gerbner, Holsti, Krippendorf, Paisley and Stone, 1969:71). Krippendorf states that four important questions must be asked:

1) what is the structure of the information that enables an analyst to make content inferences about a source?
2) how can the needed information be acquired, and what are the criteria for assessing the validity of the information?
3) how can given information be operationalized? and
4) what evidence establishes the validity of the analytical process as a whole?

Based on these issues, content analysis has been redefined as (Ibid, 11):

> the use of replicable and valid methods for making specific inferences from text to other states or properties of its source

where text refers to the raw data and source refers to data origin.

Deese (cited in Gerbner et al, 1969:39-41) contends that problems arise in analysis when it is assumed that the interpretation of the original product is the one and true interpretation. He suggests, in fact, that the interpretation will instead arise out of the needs of a praticular analysis and stresses the issues of:

1) justifying particular inferences through established theories and practices;
2) validating procedures by showing them to be derived from general principles or theories that are accepted; and
3) vindicating the analysis through the results achieved -- i.e., the method will be acceptable on the grounds that it leads to accurate predictions (stated as better than chance occurrence) regardless of the details of that method.

Pool (cited in Gerbner et al, 1969:114) noted in 1959 that standard categories to facilitate comparative and cumulative research findings were difficult to create and justify. It is suggested by Holsti (Ibid, 115) that even now it is questionable whether one can establish standards in content analysis. Measures are convenient when established by a number of researchers over time for a particular variable. However, it is neither feasible nor reasonable to expect ready application to other investigations. Categories then appear to be set up according to need of the researcher and the types of information that justify and vindicate the results achieved.

Category Development

Responses to the question on staff competencies in round one (1213 by staff nurses; 178 by Supervisors, 45 by Board Members) were classified and labelled according to the following procedure. First, the researcher sorted and grouped items according to their commonalities, but maintained the separation among the three groups of data sources. Each of the competencies was then written on an index card and the frequency of that item indicated on the card along with the rank given the competency if ranked by the respondent. The cards at this point numbered 154 for staff nurses, 74 for Supervisors, and 45 for Board Members. The cards were retained as to sample source but numbered randomly within the card set.

The card set for staff nurses was presented to two independent researchers who were asked to sort and classify the same items without prompting from the researcher. On review of those efforts, the researcher again sorted the cards and chose a set of six categories by which all the cards would be sorted.

The card sets were again presented to an independent researcher to sort against the selected categories. No definition of each category was presented at this time.

Once this sorting had been completed, A Scott's coefficient (Appendix J) was applied. Tuckwell (1980:12) utilized Scott's coefficient technique at a critical level of 0.70 as a means of testing inter and intra-judge agreement when using content analysis. Campbell (1980:32) cites Flanders (1966) conclusions as to the advantages of using this technique: unaffected by low frequencies; adaptable to percentage figures; more rapid field estimation; and increased sensitivity at higher levels of reliability. The requirments for using Scott's coefficient are that nominal scale categories be mutually exclusive and that observations be capable of duplication – both appropriate to the task in this study. Flanders (1966) cautions the technique use because of increasing error with decreasing frequency of categories and because it is concerned with percentage agreement, it is insensitive to the order in which the observations were made. Both cautions are not essential issues to this task. Campbell (1980:35) in a review of this technique concludes that while the method is not ideal, it remains the best available.

The method of Calculation of the Scott's coefficient for this study are shown in Appendix J. A level of 0.70 was deemed desirable as a minimum for this study. The initial inter-judge aggreement level was calculated at 0.755; while the intra-judge agreement was 0.80.

The cards were then reclassified reducing the total number to 60 competencies and increasing the categories from six to seven. Wording was simplified and/or clarified where appropriate and the definitions of the categories were discussed.

On two successive tests, Scott's coefficients of 1.00 and 0.97 were achieved for inter-judge testing on the staff nurse card set. The seven categories were retained and used for sorting the card sets from both the Nursing Supervisors and the Board Members. Scores of 1.00 and 0.98 were achieved respectively. Intra-judge testing consistently achieved scores of 1.00. It was therefore concluded that the categorization was reliable.

Using a content analysis approach, the remaining data from the questionnaire was processed. Data from questionnaires and tapes were tabulated on two separate occasions and comparisons made as to comprehensiveness of extraction.

Round Two

The purposes of the second round were:

1) to validate the data obtained in round one
    a) was there agreement/ disagreement with the competencies generated in round one?
    b) could some competencies be deleted? added?
    c) could additional criteria for measurement be generated?
2) to sensitize the remaining sample to the issues involved in developing and evaluation scheme for community health staff nurses;
3) to speculate on the feasibility of using the AARN Nursing Practice Standards as an evaluation model;
4) to speculate on the feasibility of using the generated competencies within the AARN standards format;

Selection of the Sample

The sample for round two consisted of those health units that were not included in the first round. Eleven health units participated in this round. Voluntary participation was limited to staff nurses and Supervisors from each unit. Board Members were excluded from the second round as in their own opinion they were poor sources of data.

The inservice was presented to the Nursing Supervisor(s) and the community health staff nurses on an availabilty basis. Several health units were unable to participate in an inservice presentation but volunteered to react to a written form of the same presentation. A questionnaire format which allowed the individual nurses and Supervisors to complete the material as either a group or as individuals was developed and mailed to those respondents requesting inclusion in this manner (Appendix O).

Entry into the health units for the second round was again negotiated through the Nursing Supervisors of the selected health units. A bulletin was issued through the Community Health Nursing Supervisors Society (Appendix K) in October to publicize and gain support for the second round. Telephone contact with individuals followed and confirmation made by letter (Appendix L, M).

Data Collection Procedures

Referred to as the "validation phase" by Manuel and Deane (1977), round two was designed to ascertain the extent of agreement with the first round findings by surveying a sample of the remaining community health nurses and Supervisors employed in the Alberta that had not been included in the initial round. Although the first round participants were thought to be representative of the total population and actually constituted over 35% of that population, Manuel and Deane (1977) strongly suggest that any profile be exposed to a larger sample for review and criticism in that no sector can be expected to have total insight into the entire population. Because the first round relied on individual efforts, it seemed important that some group efforts and reaction be gained in judging the competencies presented.

A personal contact inservice-brainstorming session was used in which the researcher presented the round one findings and encouraged criticism and corroboration through the process of elite interview techniques (Murphy, 1980). The rationale for this approach provides access by the researcher to:

1) clarify the meanings of the competency statements and illustrate the intent of the statement;
2) request clarification of judgments made on the competencies presented;
3) judge the effects of group dynamics on decision making as to the

relevancy of the competency statements; and

4) emphasize the issues involved in evaluation and by ascertaining reactions to the content and the study, direct the sample's attentions to those issues and possibly increase the significance of the overall study to the nursing practice area.

An overhead projection technique was used which could allow continuous validation of responses as they were written on the screen. Participants were cautioned to question any comments so written if they were felt to be non-representative of the discussion.

The second part of round two included the presentation of the AARN Nursing Practice Standards and a discussion by respondents as to their perceived relevancy to community health nursing. The competencies were then listed under each standard to which they were thought to apply and a discussion was entertained as to the uses of this information and the overall applicability of such competencies and/or standards to evaluation.

Health units involved in the second round were found to be extremely receptive and reactive to the materials presented. Informal conversation following the presentation suggested the purpose of issue sensitization had been achieved.

Treatment of the Data

Using content analysis and descriptive statistics, the data from round two were removed from the overhead transparencies and the questionnaires.

Reactions to the data from round one were tabulated and presented by category and by issue (evaluation methods, differences from other areas). This allowed direct comparisons to the presentation of data from round one.

The second part of round two, the application of AARN Standards to community health nursing, included discussion and the assignment of competency statements to each practice standard. This assignment is presented in tabular form and the discussions presented as to general consensus and issues through the use of content analysis techniques.

F. Summary

The study was designed in two rounds: the first required respondents to generate competencies and reflect on the current methods used to evaluate their performance; the second required respondents to examine the findings from round one and reflect on the competencies representativeness with the community health nursing population. Participants in the second round were also asked to speculate on the appropriateness of the identified competencies for use in evaluation and in combination with the AARN Nursing Practice Standards.

Interviews, mail questionnaires and document review were used in the first round; group interviews and mail questionnaires were used in the second. Each method required the development of appropriate instruments. This was done with particular attention to the issues surrounding the nature and structure of the task, the characteristics of the interviewer and the characteristics of the respondents.

Pilot tests were held in the first round to establish instrument reliability and validity and to establish the trustworthiness of the interviewer. Periodic reviews were held throughout the study to ensure researcher objectivity and the reliability of the data secured.

Content analysis using category development was used as a method of data treatment. Data were presented using descriptive statistics.

V. ANALYSIS OF DATA - ROUND ONE

The data collection was completed in two rounds as outlined in chapter four. Because of the nature of this study, the second round of data collection was based upon the data collected in the first round. The data analysis therefore is presented in the same logical sequence, the first round presented in chapter four and the second in chapter five.

The study population for round one consisted of eleven health units, one of which was an urban centre. In this latter case, five out of a possible ten health centres within that health unit were included in the study sample. Numbers within the three designated study populations included: 16 Nursing Supervisors, 8 Board Members, and 110 staff nurses.

The data collected in the first round are presented under the following headings: competencies generated, competencies discussed, setting differences, evaluation methods used, and evaluation methods desired.

A. Competencies Generated

A total of 1532 competencies were generated when data was extracted from the questionnaires and the interviews. When collapsed to those with essentially the same meaning or intent, a total of 60 competencies were noted. The competencies as described by the respondents were listed on individual cards and then placed in categories by three persons. The categories as developed were then assigned names and defined.

The competencies generated, their frequencies, and percentage frequencies are presented by category in Tables 3 to 9.

TABLE 3

PERSONAL BELIEFS AND ATTITUDES

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Positive attitude toward self and others	6	5.45	2	12.50	1	12.50
Commitment to nursing	1	0.91	0	0	1	12.50
Client centered orientation	26	23.63	3	18.75	0	0
Preventive orientation or the philosophy of community health	19	17.27	1	6.25	3	37.50
Family centered service orientation	0	0	2	12.50	0	0
Total responses and percentage of overall	52	4.28	6	3.37	5	12.19

While the responses in the category were limited (52 for staff nurses; 6 for Supervisors; and 5 for Board Members), it is interesting to note the emphasis by nurses and Supervisors on client centered orientation (23.6% and 18.7% respectively) and the reporting of preventive health orientation or philosophy of community health (17.2%, 6.25%). Board Members did not report client centered orientation as a competency but emphasized preventive orientation (37.5%). It was of note that the overall percentage of responses was approximately equal for nurses (4.28%) and Supervisors (3.37%) but not for Board Members (12.19%).

TABLE 4

PERSONAL TRAITS AND CHARACTERISTICS

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Average plus intelligence	2	1.82	0	0	1	12.50
Self-assurance	2	1.82	3	18.75	2	25.00
Good memory	2	1.82	0	0	0	0
Consistency	3	2.73	0	0	0	0
Common sense	4	3.64	1	6.25	1	12.50
Sense of humor	5	4.55	0	0	0	0
Enthusiasm	8	7.27	7	43.75	1	12.50
Versatility	14	12.72	6	37.50	1	12.50
Good natured, pleasant	0	0	1	6.25	0	0
Maturity	0	0	1	6.25	0	0
Empathy	0	0	3	18.75	1	12.50
Stability	0	0	1	6.25	1	12.50
Consideration	0	0	1	6.25	0	12.50
Total responses and percentage of overall	40	3.29	24	13.48	8	19.51

Personal traits and characteristics have traditionally been used for nursing evaluation. Nurses presented 40 responses in this category (a 3.2% of overall responses), compared to 24 (a 13.4% response total) for Supervisors and 8 (or 19.5% of the total) for Board Members. Supervisors emphasized the characteristics of enthusiasm (43.7%) and versatility (37.5%) and to a somewhat lesser degree, self-assurance (18.7%), Board Members emphasized selfassurance (25.0%). Nurses did not indicate a strong emphasis on any one particular trait or characteristic.

TABLE 5

TECHNICAL SKILLS

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Writing and recording skills	17	13.45	2	12.50	0	0
Driving skills	19	17.27	0	0	1	12.50
Screening and associated equipment skills	33	30.00	10	62.50	1	12.50
Nursing procedures	33	30.00	10	62.50	1	12.50
Immunization skills	47	42.73	0	0	1	12.50
Total responses and percentage of overall	149	12.28	22	12.35	4	9.75

Technical skills were emphasized by all three sample groups as indicated by the about equal percentage of total responses (12.2% by nurses, 12.3% by Supervisors, and 9.7% by Board Members). Driving skills were noted by nurses (17.2%) and Board Members (12.5%) but not by Supervisors. Screening skills and nursing procedures were noted by nurses (30%) and emphasized by Supervisors (62.5%). Immunization skills received more attention by nurses (42.7%) than Board Members (12.5%). Random questioning indicated that Supervisors may have included immunization skills under nursing procedures which might account for the more substantive emphasis by Supervisors on that skill area.

TABLE 6

DIRECT INTERACTION WITH CLIENTS

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Observation skills	5	4.55	0	0	0	0
Counselling skills	29	26.36	2	12.50	0	0
Interviewing skills	36	32.73	5	31.25	0	0
Interpersonal relationship skills	53	48.18	4	25.00	2	25.00
Communication skills	62	56.36	7	43.75	1	12.50
Assessment skills	73	66.36	8	50.00	1	12.50
Teaching skills	81	73.64	9	56.25	0	0
Total responses and percentage of overall	339	27.94	35	19.66	4	9.75

This category recieved the most attention from nurses (27.9% of total), somewhat less from Supervisors (19.6%) and less from Board Members (9.7%). There is an increase in percentages of both nurses and Supervisors for each skill area beginning with observation skills (4.5% and 12.5% respectively) and concluding with teaching skills (73.6% and 56.2% respectively) which may or may not indicate a hierarchical ordering or prioritization of these skill areas. All skills in this area, on questioning, were noted to overlap and the ordering of skill areas may depend upon the definition and differentiation among definitions for these skills. Board Members emphasized interpersonal relationship skills (25.0%) but also noted communication skills (12.5%) and assessment skills (12.5%).

TABLE 7

PERSONAL SKILLS

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Resourcefulness as a skill	7	6.36	4	25.00	1	12.50
Maintaining confidentiality	8	7.27	0	0	0	0
Role modelling	9	8.18	1	6.25	0	0
Personal coping ability	11	10.00	0	0	1	12.50
Responsibility in the nursing situation	18	16.36	2	12.50	0	0
Decision making skills	23	20.91	3	18.75	0	0
Ability to act independently	26	23.64	7	43.75	1	12.50
Adaptability to changes in the work setting	32	29.09	7	43.75	1	12.50
Ability to maintain competence	35	31.82	7	43.75	1	12.50
Objectivity	0	0	1	6.25	0	0
Total responses and percentage of overall	169	13.93	32	17.97	5	12.19

This category was reported fairly equally by all three respondent groups (13.9% by nurses, 17.9% by Supervisors, and 12.1% by Board Members). Nurses and Supervisors both emphasized the ability to act independently (23.6% and 43.7% respectively), adaptability to change (29% and 43.7% respectively), and the ability to maintain competence (31.8% and 43.7% respectively). Board Members showed a response rate of 12.5% on all three of these competencies. Nursing Supervisors noted resourcefulness as a skill (25.0%). All other competencies in this category received varying attention of a lesser degree from the three groups.

TABLE 8

ADMINISTRATION SYSTEM SKILLS

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Leadership skills	5	4.55	1	6.25	0	0
Public relations skills	13	11.82	0	0	1	12.50
Evaluation skills	16	14.54	7	43.75	0	0
Ability to work within the system policies	23	20.91	6	37.50	2	25.00
Ability to work as a team member	52	47.27	6	37.50	1	12.50
Knowledge of and ability to use community resources	64	58.18	7	43.75	0	0
Organizational skills	84	76.36	6	37.50	1	12.50
Planning long range care	0	0	4	25.00	0	0
Establishing and utilizing a referral system	0	0	1	6.25	0	0
Total responses and percentage of overall	257	21.18	38	21.34	5	12.19

This category received the most individual emphasis by Supervisors (21.3%) but was equally noted by nurses (21.1%), and less by Board Members (12.1%). Knowledge of and ability to use community resources,(58.1% nurses, 43.7% Supervisors, and 0 Board Members), organizational skills, (76.3% nurses, 37.5% Supervisors, and 12.5% Board Members), the ability to work within system policies, (20.9%, 37.5%, and 25% respectively), and the ability to work as a team member (42.7%, 37.5%, and 12.5% respectively), were [illegible] given particular attention. Supervisors also noted evaluation skills (43.7%) and planning long range care (25%).

TABLE 9

KNOWLEDGE

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
First aid	3	2.73	0	0	0	0
Sexuality	4	3.64	0	0	0	0
Gerontology	5	4.55	0	0	0	0
Immunology	7	6.36	1	6.25	0	0
Previous experience	8	7.27	0	0	3	37.50
Group dynamics	14	12.73	3	18.75	0	0
Nutrition	21	19.09	1	6.25	1	12.50
Epidemiology	22	20.00	4	25.00	0	0
Growth and development	54	49.09	3	18.75	1	12.50
Nursing education	69	62.73	8	50.00	5	62.50
Maternal and child health	0	0	1		0	0
Total responses and percentage of overall	207	17.06	21	11.79	10	24.39

Knowledge included references to past experience in community health and references to basic nursing education. Where specified, education was desired at a basic degree level or a requirement made that community health nursing courses be a part of that education. The education competency was strongly emphasized (62.5% by nurses, 50% by Supervisors, and 62.5% by Board Members). The category as a whole received some attention (17% by nurses, 11.7% by Supervisors, and 24.3% by Board Members). Other knowledge areas of note included growth and development (49% nurses, 18.7% Supervisors, and 12.5% Board Members), epidemiology (20%, 25%, 12.5% respectively), nutrition (19%, 6.2% and 0 respectively) and group dynamics (12.7%, 18.7%, and 0 respectively).

B. Competencies Discussed

Ranking of Competencies

While competencies were regularly ranked in terms of importance, respondents followed up such ranking with qualifying statements such as:

> I believe one (competency) is dependent on the other; one must possess all these competencies in order to function successfully.
>
> I don't believe they can be ranked in order. If you have only one without the others, the one loses its significance and value.
>
> Each of these competencies are essential to good public health performance - a nurse may be stronger in one area or another but should have some of each of the other competencies.
>
> (They) are difficult (to rank) as many are equally important. Each nurse will place different emphasis on different competencies in different settings.
>
> Because the position of community health nurse is so diversified, the competencies required depend on the situation encountered.

Because of the tendency of the respondents to rank order the competencies presented and then state that rank ordering was not significant, the ranking of the competencies is presented to show some overall prioritization of competencies rather than a true ranking. Table 10 presents the number of persons ranking the competency by nurses and Supervisors (Freq) and also presents the average ranking given the competency by those respondents ranking that particular competency (Av Rank). Board Members, as a group did not tend to rank order the competencies listed, and have not been included in the reporting of the data.

While no true prioritization of competencies occurred, those competencies ranked on the average between 1.0 and 1.9 by either nurses or Supervisors included: self-assurance (1.0), empathy (1.0), interviewing skills (1.0), decision making skills (1.0), evaluation skills (1.0), organizational skills (1.0), immunology (1.0), nursing education (1.0), interpersonal relationship skills (1.1), versatility (1.3), ability to maintain competence (1.4), adaptability to change (1.5), knowledge and use of community resources (1.5), preventive orientation (1.7), and communication skills (1.8).

Table 10 also presents the suggestions made by all respondents as to the criteria necessary for measurement of a given competency. Because these criteria were often methods or suggestions for approaches to measuring a given competency, the column has been headed "Suggestions for Measurement". In reviewing the responses in this section, the reader will notice a reliance on observation to assess many of the competencies. When asked about the time allowed for such observation, the Supervisors suggested that about one (1) percent of the nurse's actual activity could be observed. Many suggested that this was insufficient and suggested that any evaluation should be based on more than one observation, and that indeed, such observation tended to give an inaccurate presentation of the nurse's abilities because of the uniqueness of the situation or the anxiety of either the nurse or the client because of the supervisor's presence.

TABLE 10

COMPETENCIES -- RANKING AND MEASUREMENT

Competency	Nurses Freq	 Av Rank	Supervisors Freq	 Av Rank	Suggestions for Measurement
Personal beliefs and attitudes					
Positive attitude toward self and others	0	0	0	0	no comment
Commitment to nursing	0	0	0	0	observe in work setting; "sense" attitude; observe how daily crises handled;
Client centered orientation	4	2.0	0	0	no comment
Preventive orientation or the philosophy of community health	7	1.7	1	3.0	lifestyle assessment; use of preventive client counselling; active promotion of health; program emphasis;
Family centered service orientation	0	0	0	0	casefinding; case conferences; presentation of client as part of a grouping;
Personal traits and characteristics					
Average plus intelligence	0	0	0	0	no comment
Self-assurance	1	1.0	0	0	client survey; peer evaluation; self evaluation;
Good memory	0	0	0	0	no comment
Consistency	1	4.0	0	0	no comment
Common sense	1	5.0	0	0	observe application in conjunction with nursing principles; case conferences;
Sense of humor	0	0	0	0	no comment

. . . over

TABLE 10 Continued

Competency	Nurses		Supervisors		Suggestions for Measurement
	Freq	Av Rank	Freq	Av Rank	
Enthusiasm	1	4.0	0	0	observe energy in work setting;
Versatility	3	2.0	3	1.3	responsiveness to differing situations;
Good natured, pleasant	0	0	0	0	no comment
Maturity	0	0	0	0	no comment
Empathy	0	0	2	1.0	degree of involvement with clients;
Stability	0	0	0	0	absense of disabilities hampering work output; lifestyle assessment; self evaluation; preemployment medical;
Consideration	0	0	0	0	observe contacts with clients and peers for degree of responsiveness;
Technical Skills					
Writing and recording skills	3	6.6	0	0	review of records and written communications; comparison to systematic method; look for conciseness, comprehensiveness, and promptness of reports;
Driving skills	2	5.0	0	0	valid driver's license; car and business insurance; attention to car maintenance; observation in transit on different road situations;
Screening and associated equipment skills	5	5.6	0	0	monitor referrals; observe procedures;

. . . over

TABLE 10 Continued

Competency	Nurses Freq	Nurses Av Rank	Supervisors Freq	Supervisors Av Rank	Suggestions for Measurement
Nursing procedures	0	0	3	2.0	self evaluation; observe motor skills involved; check for understanding of nursing principles;
Immunization skills	10	5.5	0	0	observe technic; client survey;
Direct Interaction with Clients					
Observation skills	5	2.4	0	0	evidenced in charting, referrals, and case conferences;
Counselling skills	9	2.9	0	0	document review; check for goal setting, use of nursing process, therapeutic focus; client survey; situational role play assessment;
Interviewing skills	20	2.8	1	1.0	document review; client survey; interview observation; check for information attained, client outcome, use of questioning technic, listening skills, body language;
Interpersonal relationship skills	15	2.2	6	1.1	preset instruments to measure personality, communication skills; review work history and constructiveness of work with people;
Communication skills	24	3.1	5	1.8	client survey; document review; peer evaluation; monitor complaints; assess participation in groups; client outcomes; situational role play;
Assessment skills	19	3.1	2	2.0	observe against preestablished checklist; monitor referrals; review reports; written and/or oral testing;

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TABLE 10 Continued

Competency	Nurses Freq	 Av Rank	Supervisors Freq	 Av Rank	Suggestions for Measurement
Teaching skills	18	3.5	0	0	client survey; client outcomes; assessment of objectives, lesson plans, class interest, questions asked, teaching level appropriateness;
Personal Skills					
Resourcefulness as a skill	0	0	0	0	assess materials used and/or created in programs;
Maintaining confidentiality	4	3.0	0	0	client survey; peer evaluation; monitor appropriateness of discussions;
Role modelling	1	4.0	0	0	image in community; client survey regarding responsiveness and request for service from individual;
Personal coping ability	3	5.0	0	0	state of wellness; sick time; response to job stress; demeanor;
Responsibility in the nursing situation	2	3.0	0	0	involvement in community and professional activities; participation in meetings; rationale behind nursing decisions; performance as client advocate;
Decision making skills	7	3.5	1	1.0	use of decision making process; rationale behind decisions made; document review; ability to prioritize; assessment skills;
Ability to act independently	18	3.6	0	0	ACNARS; appropriateness of supervisor use; performance evaluation as to quality, quantity, and use of assistance from peers; work history; references; client survey;

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TABLE 10 Continued

Competency	Nurses Freq	Nurses Av Rank	Supervisors Freq	Supervisors Av Rank	Suggestions for Measurement
Adaptability to changes in the work setting	4	3.5	2	1.5	response to changes in work schedule; ability to identify potentials of situations; ability to recognize need for assistance; receptivity to change;
Ability to maintain competence	12	3.2	3	1.67	reading completed; requests and/or attendance at inservice; currentness of information offered to clients, peers, and at meetings; continuing education; involvement in research; presentation of inservice; AARN registration form;
Objectivity	0	0	0	0	record review; plan for active client disengagement;
Administration System Skills					
Leadership skills	0	0	0	0	participation in groups; committee work;
Public relations skills	6	4.3	0	0	communication patterns with peers, community, and other professionals; requests from community for programs; goal setting and evaluation;
Evaluation skills	3	4.6	1	1.0	participation in meetings, case conferences; record review; use of care plans; rationale behind care given;
Ability to work within the system policies	4	3.2	3	2.4	safe practice; absence of complaints;

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TABLE 10 Continued

Competency	Nurses Freq	 Av Rank	Supervisors Freq	 Av Rank	Suggestions for Measurement
Ability to work as a team member	4	4.7	0	0	survey of agencies as to nurse's contributions and effectiveness in the team setting; assessment of referral system and utilization;
Knowledge of and ability to use community resources	16	4.6	2	1.5	use of community resources in programs and services offered; ACNARS; participation in interagency activities; recognition of needs of community as a whole; program planning as to community focus; client survey;
Organizational skills	34	3.8	2	1.0	ACNARS; ability to set realistic goals; document review; work load; overtime required; self evaluation; back tracking necessary; time motion survey;
Planning long range care	0	0	0	0	document review; case conferences;
Establishing and utilizing a referral system	0	0	0	0	no comment
Knowledge					
First aid	0	0	0	0	practical testing; observation;
Sexuality	0	0	0	0	no comment
Gerontology	0	0	0	0	no comment
Immunology	1	1.0	0	0	knowledge of current status of diseases, immunizing agents; contraindications; application of knowledge in clinic setting;

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TABLE 10 Continued

Competency	Nurses Freq	Nurses Av Rank	Supervisors Freq	Supervisors Av Rank	Suggestions for Measurement
Previous experience	3	4.2	0	0	work history; references; past evaluations;
Group dynamics	1	9	0	0	document review; application in teaching setting;
Nutrition	3	3.6	0	0	currentness of information offered in clinic setting;
Epidemiology	5	3.6	0	0	recognition of disease states; appropriateness of treatment and referrals;
Growth and development	13	3.0	0	0	recognition of normal variations; appropriateness of referrals and counselling;
Nursing education	18	1.7	3	1.0	AARN registration; documented education level and inservice; work history; program based evaluation emphasizing skills required;
Maternal and child health	0	0	0	0	application of knowledge in counselling situation;

Setting Differences

Respondents were asked if community health nursing competencies were different than those required of nurses working in other areas. While the hospital was specifically noted as an alternate practice area, the following general statements were made. Compared to nurses working in other areas, in community health, the nurse:

1. requires more highly developed communication skills
2. requires more highly developed public relations skills
3. requires more highly developed teaching skills
4. requires more highly developed decision making skills
5. requires more highly developed organizational skills
6. requires more highly developed planning skills
7. must work independently with less backup and less direction
8. assists clients to help themselves rather than doing for the client
9. must be more flexible
10. is a generalist of nursing care as opposed to a specialist
11. uses a community orientation to illness rather than an individual patient outlook
12. works with "well" people as opposed to "sick"
13. must assess the community and be aware of its resources
14. must continually update
15. operates under a preventive rather than a curative orientation
16. requires driving skills
17. operates under a greater nursing risk
18. uses therapeutic counselling techniques as opposed to comforting techniques
19. plans long term care as opposed to short term care
20. offers non-compulsory services as opposed to compulsory services to a captive clientele in the hospital
21. sees slower, incremental responses to care
22. initiates care as opposed to following through on orders

Only seventeen respondents stated that community health nursing competencies were the same as those required by nurses in other practice arenas. These respondents were about equally distributed between staff nurses and Supervisors. No Board Members felt that practices were identical.

C. Evaluation Methods Used

Document Review

Actual documents used in each of the sixteen health units were obtained during the supervisor interview and questions posed at that time about the purpose of such an evaluation and the use of the results obtained. Five of the health centres used the same method and will be reported under the heading of the larger health unit; this leaves a total of eleven health units to be reviewed as to methods presently employed in staff nurse evaluation.

The methods used were analyzed by document according to the categories utilized by Goodykoontz (1981:42–43) so that some comparisons could be made to nursing evaluation methods in an institutional setting.

TABLE 11

DOCUMENT REVIEW ANALYSIS

1	Freq	% Freq
Evaluation Method		
Method used	10	90.90
No method used	1	9.09
Evidence for Evaluation		
Direct and Indirect Observation	5	45.45
Direct and Indirect Observation & self report	4	36.36
Self report	1	9.09
Purpose of Evaluation		
Feedback about performance	9	81.81
Improve performance, salary increase, and promotion/dismissal	2	18.18
Improve performance and promotion	0	
Improve staff/supervisor relations	1	9.09
Manpower planning/ Service protection	2	18.18
Criteria Against Which Performance Compared		
Job description	0	0
Implied expectations	2	18.18
Verbal expectations	0	0
Written expectations	8	72.72
Nurse Sees Criteria During Orientation		
Yes	8	72.72
No	2	18.18
Who Determines Criteria		
Nursing Supervisor	0	0
Nursing Supervisor with Nurse	4	36.36
Preestablished Criteria	7	63.63

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TABLE 11 Continued

	Freq	% Freq
Performance Evaluation Conducted		
Verbally and written	10	90.90
When is Evaluation Communicated to Nurse		
Immediately	1	9.09
Later appointment	9	81.81
Who Sees Evaluation		
Administrator	0	0
Personnel Director	0	0
Director/Associate Director	2	18.18
Immediate Supervisor	10	90.90
Nurse Being Evaluated	10	90.90
When Form Seen		
Beforehand	8	72.72
At Time	2	18.18
Rating Scale		
Yes	5	45.45
No	5	45.45
Range of Rating Scales		
1-3	0	0
1-5	5	45.45
1-8	0	0
1-10	0	0
Type Measurement if No Rating Scale or in addition to		
Strengths and Weaknesses	2	18.18
Written	4	36.36

. . . over

TABLE 11 Continued

	Freq	% Freq
Systematically Look at Accumulation of Different Individuals		
Yes	0	0
No	10	90.90
Evaluation of Personality Attributes or Vague Terms		
Not Done	3	27.27
Subjective	5	45.45
Definition	2	18.18

Reported Method Use

In a survey of the performance evaluation methods used in the community health setting, Nursing Supervisors of sixteen health units were interviewed. Each of these Supervisors expressed concern about the evaluation of staff nurses both as a method of documentation and as a positive growth development experience for staff nurses. While some had established methods, all expressed concern about the adequacy of those methods and stated that the present method of evaluation was or would be under revision.

In fifteen of the sixteen units, the Supervisors were directly responsible for evaluation; in ten units the supervisor was responsible for the total evaluation and in six the responsibility was shared by the unit supervisor and a higher director. No formal instruction in evaluation had been provided to any of the Supervisors on an ongoing basis.

Data from the sixteen units showed a variety of methods for evaluation of staff nurses during their first year of employment and less frequent or specified methods for periods subsequent to the first year. Performance of the new nurse was most often assessed at three months into employment and at least once more during the first year.

Board Members, as a group, indicated that while they assumed a method of evaluation existed, they were unaware of the specifics of that method. As a group, they indicated no desire to be actively involved in the evaluative process although two individuals felt that they should be more aware of the actual process employed in their health units. No recommendations for evaluation procedures were made. Therefore, Board Members have been omitted from the following discussion.

Table 12 is a presentation of the findings as to the present evaluation methods used in the health units of the respondents and the degree of satisfaction with that process as felt by those respondents. As these questions were open-ended, the frequency of occurrence cannot be listed as a percentage of the total respondents. Some offered multiple evaluative tools while others offered answers but stated that they had not yet or ever undergone an evaluation. The satisfaction is expressed on a rating scale of 1-5 where one indicated high dissatisfaction and five indicated high satisfaction with the present method. A range in the expressed satisfaction rating is provided to show the variance in response.

TABLE 12

REPORTED EVALUATION METHODS AND EXPRESSED SATISFACTION

	Nurses			Supervisors		
	#	Satis	Range	#	Satis	Range
None	21	1.00	1-2.5	1	0	0
Interviews	3	3.00	3	0	0	0
Informal feedback from coworkers	3	3.00	1-5	0	0	0
Supervisor observation	23	3.16	2-4	1	4	4
ACNARS	3	2.00	1-3	0	0	0
Self-evaluation	8	3.57	3-4	0	0	0
Combination self-evaluation and Supervisor observation	25	2.96	2-5	6	3.40	3-4
Record review	4	3.50	3-4	0	0	0
Rating form	18	3.25	2-5	7	3.41	3-4
Management By Objectives (MBO)	11	3.54	2.5-5	1	4	4
Peer review	2	2.50	2.5-4	0	0	0
Client survey	1	5.00	5	0	0	0

The methods most commonly noted by nurses as being used in the evaluation of staff nurses included: none (21), supervisor observation (23), and a combination of self-evaluation and supervisor observation (25). Other methods were noted such as rating forms (18), MBO (11), and self-evaluation (8). These may or may not have been part of the overall procedure and listed in the categories already mentioned. Satisfaction was generally confined to a neutral or slightly dissatisfied level. Those nurses not exposed to evaluation expressed high levels of dissatisfaction with that status. Supervisors reported the use of combination methods (6) and rating forms (7). Satisfaction with the method used was slightly higher than that expressed for the same methods by staff nurses.

Table 12 presents an interesting comparison to Table 13 which indicates the respondents choice for the ideal evaluation. Again, frequencies of choice are noted rather than frequency of the total respondents because of the freedom of the questioning method.

TABLE 13

RESPONDENT CHOICE FOR EVALUATION

	Nurses #	Supervisors #
Questionnaire	1	0
Peer evaluation	10	0
Annual nursing supervisor/nurse conference	2	0
Client survey	8	0
Informal evaluation only	1	0
Self-evaluation	10	3
Combination self-evaluation, supervisor observation, and record review	19	2
Supervisor observation over an extended time period	0	4
Record review	1	0
Management By Objectives (MBO)	4	4
Standard form used province wide	2	0
Specific to the position of staff nurse	2	0
Criterion based	1	0
Based on written job description	1	0

The choices for evaluation indicate some concerns with the present methods used as the method of choice was rarely the same as the method employed. Nurses noted a preference for peer evaluation (10), client survey (8), self-evaluation (10), and more elaborate combination methods (19). Supervisors showed an increased preference for MBO (4), and self-evaluation (4), and less for the combination method (2).

D. Summary

A total of 60 competencies were generated by first round participants. Competencies were categorized into six groupings under the headings of: personal beliefs and attitudes, personal traits and characteristics, technical skills, direct interaction with clients, personal skills, administration system skills and knowledge. Emphasis varied among stakeholder groups as to category and as to competencies within each category. Competencies were ranked in terms of importance by nurses and Nursing Supervisors but not by Board Members. Such ranking was accompanied by comments negating the significance of that ranking.

Suggestions for measurement of each competency were provided for most competencies. Suggestions tended to include evaluative methods rather than behavioral criteria and relied heavily on observation and client survey.

Statements distinguishing community health nursing from nursing in other practice areas were offered by all three stakeholder groups.

Evaluation methods used by health units were investigated by examining formal documents and by reviewing descriptions of those procedures by both nurses and Nursing Supervisors. Board Members were unable to provide descriptions of actual methods used but expressed assurance that formal procedures existed. Nursing Supervisors expressed slightly higher satisfaction with the methods currently employed than did nurses within their health units. Methods most commonly noted by nurses included: none, supervisor observation and a combination of supervisor observation and self-report. Supervisors reported the use of combination methods and rating forms. Choices for evaluation rarely mirrored methods employed within the health units. Nurses expressed a preference for peer review, client survey, self-evaluation and combination methods stressing supervisor observation, self-evaluation and document review. Nursing Supervisors indicated a preference for management by objectives approaches and self-evaluation.

VI. ANALYSIS OF DATA - ROUND TWO

A. Introduction

The purposes of the second round of data collection were to:

1) validate the competencies generated by first round participants;
2) extend the criteria for measurement;
3) validate the comments as to differences from other nursing practice areas;
4) gauge reactions to the evaluation methods presently used and to those chosen as ideal;
5) speculate on the appropriateness of the AARN Nursing Practice Standards utilization for community health nurse evaluation; and
6) assign identified competencies to each of the AARN Nursing Practice Standards.

In order to meet the above purposes, two data collection procedures were used: (1) a two to three hour group interview and brainstorming session (Appendix N) and (2) an extensive questionnaire which followed the presentation format in a programmed booklet (Appendix O). By using two procedures, one involving personal contact with the researcher and the second providing no contact, an inference was gained as to the extent of possible researcher bias. Since the responses from both procedures were similar in content, researcher bias was consider to be of no significance.

The groups receiving the questionnaire varied in their reaction and response to the task. Two groups completed only the initial segment of the questionnaire, one supplied a summary of overall comments and reactions, while the remainder completed the booklet in full and in sequence.

Reactions of both respondent groups to the overall task was favorable. Many asked for further input and discussed their individual concerns with nursing evaluation, their present evaluation programs, and possible future use of the study findings.

To present the second round findings, the following format is used. Each category is presented and discussed in terms of the respondents reaction to the individual competencies. Individual competencies with which respondents indicated some concern and/or disagreement are presented separately. A percentage disagreement of less than 20% was arbitrarily set as an indication of the consensus validation of the competency. Overall reaction to the findings is included in this discussion.

A tabular presentation of the suggestions for measurement follows a discussion of each category. This allows the reader to compare second round participant attempts at criteria for measurement with those achieved in the first round (Table 10). A presentation of the discussion and comments of the respondents to the present and desired methods of evaluation follows. Next, a presentation, again in tabular form, of the group reaction to the statements of practice area differences is made.

The chapter concludes with a presentation of the application of the generated competencies to the various AARN Nursing Practice Standards and of the comments related to the use of these standards for community health nurse evaluation.

The reader is reminded that respondents in the second round participated in groups and therefore the findings presented represent the group consensus and not the individual feelings of the participants. The effect of brainstorming and group collective agreement was seen as an important aspect of the evaluative process by the researcher.

Eleven groups were included in the second round. Groups consisted of the nursing supervisor(s) and as many staff nurses as available and willing to participate. Numbers within these groups varied from two to thirty three. Group interview (six) numbers ranged from five to thirty three while mail respondents (five) ranged from two to eleven.

B. Category A: Personal Beliefs and Attitudes

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 14.

TABLE 14

PERSONAL BELIEFS AND ATTITUDES

VALIDATION FINDINGS

	Disagree	% Disagree
Positive attitude toward self and others	0	0
Commitment to nursing	6	54.54
Client centered orientation	0	0
Preventive orientation or the philosophy of community health	0	0
Family centered service orientation	1	9.09

All competencies, with the exception of commitment to nursing, were validated in the second round. Most respondents suggested that client centered orientation and family centered service orientation be combined as both emphasized individualized client care while visualizing the client as part of a group such as the family and/or community.

Commitment to Nursing

54.5% of respondents, however, felt that commitment to nursing, while desirable and helpful, did not constitute a necessity for competence. Discussions as to the relevance of this competency revealed a need for further definition. Questions arising from these discussions included:

1) does commitment to nursing mean that nursing must come before anything else?
2) does commitment relate to a belief in the concept of wellness? In personal coping ability?
3) should commitment be balanced between personal and job related performance?
4) does commitment to nursing mean being unwilling to consider other career choices?

Based on these concerns, and the percentage disagreement, the consensus of opinion was that commitment to nursing should be deleted from the list of competencies unless more specifically defined. No one definition was agreed upon.

C. Category B: Personal Traits and Characteristics

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 15.

TABLE 15

PERSONAL TRAITS AND CHARACTERISTICS

VALIDATION FINDINGS

	Disagree	% Disagree
Average plus intelligence	9	81.81
Self-assurance	1	9.09
Good memory	6	54.54
Consistency	1	9.09
Common sense	0	0
Sense of humor	5	45.45
Enthusiasm	1	9.09
Versatility	0	0
Good natured, pleasant	3	27.27
Maturity	4	36.36
Empathy	1	9.09
Stability	3	27.27
Consideration	2	18.18

Personal traits and characteristics, as a category, appeared to present the greatest difficulty when respondents attempted to validate the list of competencies. Respondents initially, on an individual basis, considered each competency necessary for a nurse in a community health position to be successful. Yet, on further examination, no level of competence could be specified as desirable and indeed the respondents felt that a mixture among staff was essential. The consensus of opinion suggested that the listing, as presented, was vague, the terms ambiguous, and evaluation would necessarily be subjective. However, it was suggested that all the above competencies be considered at least prior to employment and possibly during orientation but not on an ongoing annual basis.

Average plus intelligence

81.8% of the respondents felt that community health nurses did not have to be above average in intelligence in order to be considered competent. Four (36%) respondents felt that nurses were assumed to have at least average intelligence and possibly slightly above average intelligence in order to have graduated from a school of nursing.

Good Memory

Good memory was considered an "ideal" competency which would be helpful in the performance of the position but was not a requirement for competence. The ability to organize work such that information could be easily retrieved was considered more important than actual memory.

Sense of Humor

While most respondents felt a sense of humor was essential to the position, the difficulty in definition and measurability caused 45.4% of the respondents to disclaim it as a necessity for competence and consider it as an "ideal" characteristic instead.

Good natured, pleasant

Seen as an "ideal" competency, good naturedness was not seen as a requirement for competence. Two respondents (18%) felt that a high level of this competency might actually be detrimental to the performance of the position.

Maturity

36.3% of the respondents disagreed with maturity as a competency. It was suggested that "maturity develops with time" and that different expectations would be held in various settings and with varying levels of experience.

Stability

27.2% of respondents disagreed with the competency of stability because of the ambiguous nature of the word rather than the necessity for "physical and emotional capabilities consistent over an extended period of time and in a number of settings."

Overall

Traits and characteristics, although given initial validation as competencies required for successful performance as a community health nurse, were categorically disclaimed as competencies to be examined in evaluation. The characteristics of above average intelligence, good memory, sense of humor, good naturedness, maturity, and stability were designated as ideal rather than required. Additional characteristics of flexibility, resourcefulness, and adaptability were suggested for inclusion in future listings.

D. Category C: Technical Skills

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 16.

TABLE 16

TECHNICAL SKILLS

VALIDATION FINDINGS

	Disagree	% Disagree
Writing and recording skills	2	18.18
Driving skills	6	54.54
Screening and associated equipment skills	2	18.18
Nursing procedures	0	0
Immunization skills	1	9.09

With the exception of driving skills, the remaining competencies in this category were essentially validated with less than 20% disagreement among the respondents. One respondent suggested that most screening and innoculating could be performed by adequately trained paraprofessionals, and thus these did not constitute competencies. This view, however, was not shared by the other respondents.

Driving Skills

54.5% of respondents disagreed that driving skills constituted a competency for community health nurses. Driving skills were described as an "asset but not a necessity" affecting "efficiency rather than competence." Speculation was made that there might conceivably be communities where public transport, bicycles, or walking could provide the necessary means of transport rather than driving. No such communities could be identified.

Overall

Three groups (27%), in examining these competencies, questioned whether community health nurses were becoming "very specialized." On review of the first round findings, one respondent expressed surprise at the limited emphasis placed on writing and recording skills and questioned how else information was to be relayed.

E. Category D: Direct Interaction with Clients

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 17.

TABLE 17

DIRECT INTERACTION WITH CLIENTS

VALIDATION FINDINGS

	Disagree	% Disagree
Observation skills	0	0
Counselling skills	2	18.18
Interviewing skills	0	0
Interpersonal relationship skills	0	0
Communication skills	0	0
Assessment skills	0	0
Teaching skills	0	0

All the above competencies were validated, however, most respondents (54%) felt many of the skills, observation, counselling, interviewing, and interpersonal skills, to be interdependent and/or able to be categorized under the one global competency of communication skills. Whatever the method of presentation, all competencies were considered "necessary when working with people" and "difficult to measure."

F. Category E: Personal Skills

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 18.

TABLE 18

PERSONAL SKILLS

VALIDATION FINDINGS

	Disagree	% Disagree
Resourcefulness as a skill	2	18.18
Maintaining confidentiality	0	0
Role modelling	9	81.81
Personal coping ability	0	0
Responsibility in the nursing situation	0	0
Decision making skills	0	0
Ability to act independently	1	9.09
Adaptability to changes in the work setting	0	0
Ability to maintain competence	0	0
Objectivity	0	0

Only one competency, role modelling, was not validated by second round participants. Some disagreement as to the definition of resourcefulness resulted in a small percentage of disagreement (18%) with that competency.

Role Modelling

While most respondents voiced concerns that role modelling increased the nurse's credibility among his/her clients, 81.8% disagreed that role modelling should be considered a requirement for successful community health nursing. The ability to act as a role model, to a "realistic" degree, was considered "ideal" but concern was expressed as to "how far role modelling should extend" or "what type of role modelling should occur."

G. Category F: Administration System Skills

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 19.

TABLE 19

ADMINISTRATION SYSTEM SKILLS

VALIDATION FINDINGS

	Disagree	% Disagree
Leadership skills	7	63.63
Public relations skills	1	9.09
Evaluation skills	2	18.18
Ability to work within the system policies	2	18.18
Ability to work as a team member	0	0
Knowledge of and ability to use community resources	0	0
Organizational skills	0	0
Planning long range care	2	18.18
Establishing and utilizing a referral system	1	9.09

All competencies, with the exception of leadership skills, received validation from respondents. Evaluation skills and the ability to plan long range care were competencies assigned to the supervisor by 18% of the respondents. The ability to work within system policies received cautionary validation (18%) and discussion indicated a concern that nurses not only work within policies but also question policies. As one respondent put it a community health nurse must be able to work within policies but should be encouraged to question and challenge the system rather than accept the status quo without question.

Leadership skills

63.6% of respondents disagreed that leadership skills constituted a competency. Leadership within the community and group teaching settings was specified as "ideal" but concern was expressed about leadership in the peer work setting. This concern was summed up in the statement "not everybody in an organization needs to be or even should be a leader."

Overall

Findings from the first round were accepted by respondents. A positive recognition was made of the emphasis placed on organizational skills and the knowledge of and ability to use community resources. Both competencies were seen as permitting "efficient use of time and resources."

H. Category G: Knowledge

The competencies included in this category and the numbers and percentages of groups having some concern and/or disagreement with the individual competencies are shown in Table 20.

TABLE 20
KNOWLEDGE
VALIDATION FINDINGS

	Disagree	% Disagree
First aid	3	27.27
Sexuality	0	0
Gerontology	1	9.09
Immunology	1	9.09
Previous experience	7	63.63
Group dynamics	2	18.18
Nutrition	0	0
Epidemiology	2	18.18
Growth and development	0	0
Nursing education	3	27.27
Maternal and child health	2	18.18

Three competencies in this category were identified as not constituting competency requirements – first aid (27.2%), previous experience (63.6%), and nursing education (27.2%).

First aid

The need for competency in first aid was felt to depend on the setting in which the nurse operated. Several respondents felt competency would be required within their particular area but recognized that not all community health nurses would require knowledge in that area.

Previous Experience

Surprise was registered that previous experience should constitute a competency. Respondents felt the need for specific experience should be specified in advance of employment, that nurses must "begin somewhere," and that previous experience was "not essential." Some experience was seen as "obviously necessary but could be learned on the job."

Nursing Education

27.2% of respondents disagreed that nursing education should be considered a competency requirement. Some disagreement and/or confusion existed as to the definition of nursing education. One respondent cautioned that a specific knowledge level could not be assumed on graduation because of the variation of training and educational experiences.

Overall

The necessity for competency in the area of knowledge was recognized by all respondents. The degree or level and type of knowledge required for community health nursing was seen as dependent on the setting in which the nurse worked. As one respondent suggested:

> If doing a full program you should be competent in all areas. If not, (you) should be competent in areas pertaining to what you are doing."

I. Suggestions for Measurement

Table 21 presents the criteria for measurement for each of the competencies as identified by round two participants. The validation status provided in round two is also indicated. This status refers to the less than 20% disagreement preestablished standard.

TABLE 21

COMPETENCIES -- VALIDATION AND MEASUREMENT

Competency	Validated		Suggestions for Measurement
	Yes	No	
Personal beliefs and attitudes			
Positive attitude toward self and others	Y		observe interaction between nurse and clients/coworkers; client survey; monitor conversation for positive content; lack of negative complaints; lack of extremes in appearance; relationship to the community; acceptance of others for what they are; willingness to accept challenge; self-confidence; ability to ask for assistance;
Commitment to nursing		N	observe in work setting; observe how daily crises handled; participation in professional organization; ongoing interest in work; professional characteristics: maintain confidentiality, honest, ethical; oriented towards people;
Client centered orientation	Y		to be combined with family centered service; peer review; help individual maintain position in family and community; includes client in planning care; checks out client circumstances; record review; case conferences; presentation of client as unique; self-evaluation;
Preventive orientation or the philosophy of community health	Y		lifestyle assessment; use of preventive client counselling; active promotion of health; anticipatory nursing care; attempts to educate public in disease and accident prevention;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Family centered service orientation	Y	casefinding; case conferences; presentation of client as part of a grouping; see client centered orientation;
Personal traits and characteristics		
Average plus intelligence	N	adjustment to job;
Self-assurance	Y	self-confidence; ability to withstand job pressures; ability to perform duties; followthrough on work activities;
Good memory	N	method of charting; ability to retreive information rapidly, accurately; application of trait to work situation;
Consistency	Y	treat client with respect despite social standing, religion, etc.; client survey; peer review; allow for humanness and uniqueness of feelings and response by nurse to client situation;
Common sense	Y	observe application in conjunction with nursing principles; ability to give advice which client is able to cope with; realistic counselling; adjustment to institutional demands; use of appropriate language and teaching levels;
Sense of humor	N	ability to laugh at self and others; monitor conversation; subjective evaluation;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Enthusiasm	Y	openness to new ideas; enjoyment or feeling level applied to work; efficiency;
Versatility	Y	responsiveness to differing situations; ability to cope with all age groups in all settings and situations; ability to operate under adverse conditions; good personal coping mechanisms; enthusiasm in the face of plan changes;
Good natured, pleasant	N	approachable; lack of negative complaints;
Maturity	N	ability to take criticism and handle problems efficiently; client survey; task completion;
Empathy	Y	ability to relate to others problem in an attempt to understand; client survey;
Stability	N	frequency of need to cope; consistency of coping ability; reliability in work setting;
Consideration	Y	ability to consider another point of view and respect the person offering it; willingness to work with others;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Technical Skills		
Writing and recording skills	Y	review of records and written communications; comparison to systematic method; look for conciseness, comprehensiveness, promptness of reports, legibility, objectivity, and the ability for another person to follow,
Driving skills	N	valid driver's license; attention to car maintenance; observation in transit on different road situations; preemployment specification; defensive driver certificate; driving record: number of at-fault accidents; peer review;
Screening and associated equipment skills	Y	monitor referrals; observe procedures against a checklist; test-retest by nurse and with one other person to check inter and intra rater reliability; ongoing evaluation; maintenance of equipment noting frequency of required repairs, reporting of mechanical failures; paper test on normal range of findings;
Nursing procedures	Y	self evaluation; observe motor skills involved; check for understanding of nursing principles;
Immunization skills	Y	observe technic; client survey; self-evaluation; know rationale behind procedures; knowledge of current policies and practices;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Direct Interaction with Clients		
Observation skills	Y	evidenced in charting, referrals, and case conferences; observable by a third party; use of an arbitrary scale; ability to assess non-verbal messages; setting of objectives prior to session and reflecting on success following session; self-evaluation; client survey: how clients react to nurse, how services utilized;
Counselling skills	Y	document review; situational role play assessment; use of videotaping, audiotaping; lack of negative feedback; peer and Supervisor evaluation: comparison of interaction evaluations; ability to search and retrieve necessary information from client;
Interviewing skills	Y	document review; check for information attained; client outcome; amount of contact made between nurse and client; application of knowledge;
Interpersonal relationship skills	Y	ability to get along with others;
Communication skills	Y	ability to communicate; includes observations skills, counselling skills, interviewing skills, and interpersonal relationship skills;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Assessment skills	Y	observe against preestablished checklist; monitor referrals; review reports; ability to assess delays in normal growth patterns and home management abilities; self-evaluation; record review: problem identification, SOAP charting, noting thoroughness and individuality of assessment; ability to assess the community in terms of program requirements;
Teaching skills	Y	client survey; client outcomes; assessment of objectives, lesson plans; class interest; questions asked; teaching level appropriateness; ability to teach must not be dependent on client's change in behavior; peer review; external or internal subject specialist review; observation in small group and one to one teaching situations; attendance at classes; demand for classes; use of resources;
Personal Skills		
Resourcefulness as a skill	Y	knowledge and use of resources; individual contact and appropriateness of referrals; ability to utilize available information; methods of handling problems; programs developed; creativity in work setting;
Maintaining confidentiality	Y	client survey; peer evaluation; monitor appropriateness of discussions; review professional interchanges; record handling; consents obtained for release of information; use of family roster; lack of negative complaints;
Role modelling	N	image in community; client survey; lack of negative complaints;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Personal coping ability	Y	sick time; response to job and personal stress; abilty to complete tasks despite interruptions; balance achieved between home and work demands;
Responsibility in the nursing situation	Y	reliability in the work setting; ability to work within system policies; ability to step out of client situations where non-effective; ability to take the consequences of each nursing action; review of decisions made; critical incident technique; requesting assistance as needed;
Decision making skills	Y	use of decision making process; appropriateness of requests for assistance; ability to go ahead with and make progress in programs; organizational skills; response to community needs; review of decisions made;
Ability to act independently	Y	ACNARS; appropriateness of supervisor use; work history; references; client survey; work accomplished; initiative to go ahead on own to set up and/or change programs; peer review; supervisor evaluation; amount of followup needed; depends on setting;
Adaptability to changes in the work setting	Y	response to changes in work schedule; ability to identify potentials of situations; receptivity to change; client survey; peer review; ability to reschedule in emergencies; ability to use physical settings to advantage;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Ability to maintain competence	Y	reading completed; requests and/or attendance at inservice; currentness of information offered to clients, peers, and at meetings; self-evaluation; interest in learning; use of current policies, techniques, and information; evidence of application of new knowledge; client survey;
Objectivity	Y	record review; observation of counselling; ability to step back from involvement in care; self-evaluation; ability to accept criticism and build on suggestions; awareness of role in client setting; reflection on cases; record review: lack of subjective recording, biased judgmental statements, unsubstantiated findings;
Administration System Skills		
Leadership skills	N	participation in groups; ability to move clients towards a goal; willingness to accept a leader role; ability to recognize personal limitations; peer review; ability to organize and initiate activity;
Public relations skills	Y	communication patterns with peers, community, and other professionals; ability to publicize programs; ability to meet the public; availability to public; relationship with peers;
Evaluation skills	Y	inclusion of evaluation in programs; recognition of personal weaknesses; ability to participate in evaluations; ability to set priorities; ability to set realistic results-oriented goals;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Ability to work within the system policies	Y	safe practice; absence of complaints; monitor choices made outside existing policies; ability to seek out reasons behind existing policies; ability to relate concerns about policies in the appropriate setting; ability to see potentials of policies; ability to cooperate with staff; ability to recognize stress and to maintain positive feelings in work setting;
Ability to work as a team member	Y	survey of agencies as to nurse's contributions and effectiveness in the team setting; assessment of referral system and utilization; peer review; ability to get along with team members to ensure optimal productivity and quality of work; review of tasks completed in teams; attendance and involvement of nurse in case conferences, staff meetings; sharing of information with colleagues; provision of support for peers;
Knowledge of and ability to use community resources	Y	use of community resources in programs and services offered; client survey; record review; quantity and appropriateness of referrals; agency feedback; review of existing services with those commonly used;
Organizational skills	Y	ACNARS; backtracking necessary; work completed; ability to organize work schedule: monthly calendars, yearly agenda and goals; ability to cope with emergencies; ability to set priorities;
Planning long range care	Y	document review; evidence of realistic goal setting and achievement planning; ability to integrate program; ability to set priorities; ability to develop timetables;

. . . over

TABLE 21 Continued

Competency	Validated	Suggestions for Measurement
Establishing and utilizing a referral system	Y	use of referral procedures; appropriateness of referrals; record review; crisis interventions; participation with agencies and other resource possibilities;
Knowledge		
First aid	N	application of knowledge in work; paper tests; client survey; peer review; ability to seek information as needed; record review: evidence of background knowledge for decisions; willingness to update; self-administered examinations on content knowledge; use of self-learning aids;
Sexuality	Y	same as first aid;
Gerontology	Y	same as first aid;
Immunology	Y	same as first aid;
Previous experience	N	no comment;
Group dynamics	Y	same as first aid;
Nutrition	Y	same as first aid;
Epidemiology	Y	same as first aid;
Growth and development	Y	same as first aid;
Nursing education	N	no comment;
Maternal and child health	Y	same as first aid;

J. Reaction to Evaluation Methodology

No surprise was registered as to the present methods of evaluation used by first round participants or by the methods chosen as ideal. Comments mirroring the respondent consensus included:

> the best (methods) seem to be a combination of the above (methods presented) depending on the situation
>
> a combination of peer, self, supervisor, and record evaluation based on well written job descriptions and annual personalized objectives (would be ideal).

K. Differences From Other Nursing Practice Areas

Respondents were asked to agree or disagree with the statements made as to the differences in community health from other nursing practice areas. Table 22 presents the frequency of agreement and the percentage of agreement with each statement by the second round groups. Again, the findings represent a consensus of opinion rather than individual reactions.

TABLE 22

DIFFERENCES FROM OTHER NURSING PRACTICE AREAS

VALIDATION FINDINGS

	Agree	% Agree
requires more highly developed communication skills	4	36.36
requires more highly developed public relations skills	4	36.36
requires more highly developed teaching skills	3	27.27
requires more highly developed decision making skills	5	45.45
requires more highly developed organizational skills	2	18.18
requires more highly developed planning skills	3	27.27
must work independently with less backup and less direction	8	72.72
assists clients to help themselves rather than doing for the client	8	72.72
must be more flexible	4	36.36
is a generalist of nursing care as opposed to a specialist	5	45.45
uses a community orientation to illness rather than an individual patient outlook	6	54.54
works with "well" people as opposed to "sick"	9	81.81
must assess the community and be aware of its resources	7	63.63
must continually update	3	27.27
operates under a preventive rather than a curative orientation	9	81.81
requires driving skills	8	72.72
operates under a greater nursing risk	2	18.18
uses therapeutic counselling techniques as opposed to comforting techniques	5	45.45
plans long term care as opposed to short term care	5	45.45
offers non-compulsory services as opposed to compulsory services to a captive clientele in the hospital	7	63.63
sees slower, incremental responses to care	7	63.63
initiates care as opposed to following through on orders	8	72.72
is no different than nurses working in other areas	0	0

Respondents, on initial questioning, agreed that, in some ways, community health nursing differed from nursing in other practice areas. When reacting to statements made by their counterparts however, considerable differences in opinion were evident. The findings in Table 16 represent the group consensus of these reactions rather than individual opinions. Those statements with which more than 50% of the respondents agreed include those in which the community health nurse: must work independently with less backup and less direction (72%), assists clients to help themselves rather than doing for the client (72%), uses a community orientation to illness rather than an individual patient outlook (54.5%), works with "well" people as opposed to "sick" (81.1%), must assess the community and be aware of its resources (63,6%), operates under a preventive rather than a curative orientation (81.8%), requires driving skills (72.7%), offers non–compulsory service as opposed to compulsory services to a captive clientele in the hospital (63.6%), and initiates care as opposed to following through on orders (63.6%).

It is of interest to note that no respondents in the second round considered community health nursing to be "no different from that experienced by nurses working in other areas."

L. AARN Nursing Practice Standards

Applicability of Use with Generated Competencies

Respondents were asked to assign the competencies generated in the first round to those AARN standards, (Appendix N), to which they were thought to apply. Competencies could be used more than once or not at all. Table 23 presents the frequency with which each competency was assigned to each of the six Nursing Practice Standards.

Respondents were able to assign identified competencies to the various Nursing Practice Standards. Recognition was given to the duplication of assignment particularly using those standards from categories A (personal beliefs and attitudes), D (direct interaction with clients) and E (personal skills). This overlap was speculated as suggesting some "priority" in competencies and it was suggested that those most frequently mentioned might constitute "core" competencies. While it was noted that competencies might further define the standard as to community health application, respondents questioned whether standards remained too broad to be of significant use in community health nursing evaluation. Identified competencies, however, were thought to be readily applicable and a suggestion was made that such application "might bring community health nursing from a totally intuitive process to one that is analytical as well."

TABLE 23

ASSIGNMENT OF COMPETENCIES TO STANDARDS

Competency	Nursing Practice Standards 1	2	3	4	5	6
Personal Beliefs and Attitudes						
Positive attitude toward self and others	1	1	1	2	1	1
Commitment to nursing	0	1	0	0	0	0
Client centered orientation	2	2	6	4	4	3
Preventive orientation or the philosophy of community health	0	0	2	1	1	0
Family centered service orientation	0	1	4	4	3	2
Personal Traits and Characteristics						
Average plus intelligence	0	1	0	1	1	0
Self-assurance	0	2	1	0	1	0
Good memory	1	2	0	0	1	0
Consistency	1	2	1	1	2	2
Common sense	0	2	1	1	2	1
Sense of humor	0	1	0	0	1	0
Enthusiasm	0	1	0	0	1	0
Versatility	0	1	1	1	3	1
Good natured, pleasant	0	2	0	0	1	0
Maturity	0	3	1	1	2	1
Empathy	0	1	3	1	2	1
Stability	0	1	0	0	1	0
Consideration	0	1	2	1	2	1

. . . over

TABLE 23 Continued

Competency	Nursing Practice Standards 1	2	3	4	5	6
Technical Skills						
Writing and recording skills	9	9	8	6	7	5
Driving skills	0	0	0	0	2	0
Screening and associated equipment skills	6	7	1	0	4	1
Nursing procedures	1	3	2	0	6	2
Immunization skills	1	1	1	0	2	0
Direct Interaction with Clients						
Observation skills	10	6	5	7	7	7
Counselling skills	2	4	5	5	6	5
Interviewing skills	7	4	6	6	5	5
Interpersonal relationship skills	5	4	6	5	4	3
Communication skills	8	6	6	6	8	6
Assessment skills	8	7	6	7	6	7
Teaching skills	0	3	4	4	7	2
Personal Skills						
Resourcefulness as a skill	2	4	2	3	3	3
Maintaining confidentiality	8	6	7	7	7	7
Role modelling	0	0	0	1	1	0
Personal coping ability	0	0	0	1	1	0
Responsibility in the nursing situation	2	3	2	1	4	2
Decision making skills	2	6	6	6	7	3
Ability to act independently	0	2	2	3	3	1
Adaptability to changes in the work setting	2	1	3	3	3	3
Ability to maintain competence	1	1	1	2	2	2
Objectivity	6	4	4	3	5	5

. . . over

TABLE 23 Continued

Competency	Nursing Practice Standards 1	2	3	4	5	6
Administration System Skills						
Leadership skills	0	0	3	4	3	5
Public relations skills	3	2	2	2	3	4
Evaluation skills	3	6	6	6	5	7
Ability to work within the system policies	1	3	4	2	2	0
Ability to work as a team member	3	5	8	7	5	6
Knowledge of and ability to use community resources	3	4	6	8	5	3
Organizational skills	3	4	4	6	4	6
Planning long range care	4	6	9	5	6	5
Establishing and utilizing a referral system	2	4	5	6	6	3
Knowledge						
First aid	2	7	3	2	5	5
Sexuality	2	7	3	2	5	5
Gerontology	2	7	3	2	5	5
Immunology	2	7	3	2	5	5
Previous experience	3	7	3	3	6	6
Group dynamics	3	8	3	2	5	5
Nutrition	2	7	3	2	5	5
Epidemiology	2	7	3	2	5	5
Growth and development	3	9	3	3	6	7
Nursing education	3	8	3	3	6	5
Maternal and child health	2	7	3	2	5	5

Applicability of Use in Evaluation

Respondents acknowledged the applicability of the AARN Nursing Practice Standards to community health nursing practice, yet questioned how the individual standards might be applied specifically to the evaluation of individual staff nurses. It was suggested that before standards could be used, it was necessary to specify the community health practice arena, client situations and the setting in which they occurred. The standards "seemed to apply" but "further guidelines were necessary to specify how." As one respondent declared:

> I feel that the AARN standards can be used in evaluation of community health nurses. With more experience personally to this format I will be more comfortable. I can see merit in using these standards in so many areas but have not become familiar with translating community health in these terms.

M. Summary

A total of 45 competencies were validated by second round participants when a 80% agreement was used as an arbitrary measure of significance. Group consensus was used to ascertain validation rather than individual responses.

Suggestions for measurement were provided for all 60 competencies whether or not the competency was validated. Suggestions continued to include methods of evaluation but greater success was achieved in obtaining behavioral characteristics to ascertain competence.

While all groups agreed that community health nursing differed from that practiced in other areas, only nine of the twenty-two statements of differences obtained in round one were agreed upon by over 50% of the groups.

Respondents assigned identified competencies to each of the six AARN Nursing Practice Standards, many competencies being used more than once and on numerous occasions assigned to all six standards. While agreement existed as to the applicability of the AARN standards to community health nursing practice, concern was expressed over the nature of that application.

VII. DISCUSSION OF FINDINGS

In this chapter a discussion of the findings of the last two chapters in relation to the problems addressed in the study is presented. The discussion is structured around the following areas of investigation:

1) the state of evaluation methodology,
2) community health nursing competencies,
3) differences from other settings,
4) the use of AARN Standards,and
5) a reflection on the conceptual framework and literature underpinning this study.

To this end, the resolution of the problems posed at the initiation of this study is addressed individually and speculation is made on the implication of those findings.

A. Evaluation Methodology

What was the state of the art of community health nursing competency evaluation at the time this study was undertaken?

The state of the art of community health nursing evaluation was inferred from a number of factors, including:

1) the methodologies employed in the surveyed health units;
2) the acceptance by stakeholders of those methods;
3) the satisfaction expressed by stakeholders with those methods;
4) the choice by stakeholders of ideal methods for evaluation; and
5) the knowledge of respondents as to competencies, evaluative criteria, and conceptual frameworks for designing and implementing evaluative processes.

Each of these factors will be addressed individually.

What methodologies were employed?

Three techniques were employed to gain information on the methods of community health nurse evaluation actively employed in the health unit samples, including:

1) document review of actual formal methods;
2) survey investigation into the perspectives of the three stakeholder groups as to the methods employed and their reactions to that method;
3) survey investigation on a second sample to validate the reported methods as to their representativeness of the larger population.

Document Review

A number of characteristics were discovered in a review of the formal evaluation procedure employed in eleven health units in the province of Alberta. Ten health units (90.9%) used some formal method of evaluation, five (45.4%) using direct and indirect observation, and another five (45.4%) including self report. The primary purpose was reported as feedback about performance (81.8%). Some form of written expectations were used as criteria against which an individual's performance was compared (72.7%). The nurse saw the criteria during orientation (72.7%) but criteria were preestablished (63.6%) as opposed to being established jointly by the supervisor and nurse (36.3%). The evaluation was conducted verbally and in written form (90.9%), communicated to the nurse at a later date (81.8%), and seen only by the supervisor and the nurse being evaluated (90.9%). Rating scales of a one to five numeration were used by 45.4% of the units with 36.3% adding some additional written comments. The accumulated evaluations of several individuals were not examined systematically (90.9%). Personality attributes were evaluated in 63.6% of the units, 18.1% defining those attributes formally, and 45.4% subjectively.

The methods used were analyzed according to a format outlined by Goodykoontz (1981) so that comparisons could be made between nurse evaluations performed in an institutional setting and those performed in the community health setting. When compared to evaluation methods completed in a institutional nursing setting, the following differences existed:

1) more emphasis was placed on self report in community health; institutions emphasized direct and indirect observation;

2) the purpose of evaluation emphasized improvement of performance in community health rather than salary and promotional considerations;
3) no written job descriptions were available in community health with more reliance placed on written expectations;
4) criteria were more often preestablished in community health with limited input from the supervisor and nurse; institutions used job descriptions plus implied and verbal expectations;
5) evaluation results were most often communicated at a later date in community heath; institutions were equally distributed between providing immediate feedback and delaying reporting of results;
6) evaluation results were most often seen only by the nurse and immediate supervisor in community health; institutions more often extended this to include Directors;
7) an equal number of health units used and did not use rating scales;
8) in both institutions and community health, the evaluation reports of different individuals were not examined as a unit;
9) the evaluation of attributes and the use of vague terminology were equally common in the evaluation methods of both institutions and community health units.

From the above comparisons, it would appear that institutions employ more systematic and formal evaluation procedures based on job descriptions and are completed on a regular schedule. Health units were less consistent in their evaluative efforts. This might suggest that health units could look to institutions for direction when attempting to evaluate nursing competence. The use of arbitrary rating scales, vague terminology and limited input from stakeholders suggests that both health units and institutions require further development in the area of personnel evaluation.

Reported Use and Validation Findings

The methods reported as used by Supervisors were similar to those reported in the document review. Supervisors, however, expressed dissatisfaction with their present methods and expressed an intention to review and/or revise these methods.

Considerable discrepancy existed between the methods reported as used by staff nurses and those reported by Supervisors. For example, twenty-one nurses reported no method at all or qualified the existence of a formal procedure with statements to the effect that they had never been personally evaluated. Nursing Supervisors, within those same health units, however, reported the use of formal evaluative procedures.

Board members, as a group, disclaimed knowledge of the formal evaluation procedures used for community health nurses but expressed unanimous assurance that such procedures were routinely performed.

The respondents in the second round, on examination of the findings of the first round, expressed no surprise and agreed that the methods presented essentially reflected their own methods. All health units in the second round used a formal evaluation procedure; the specifics of these procedures were not requested and/or volunteered.

The discrepancy between formal procedures and knowledge of those procedures by participants suggests that evaluation procedures are not well understood. One wonders whether this situation indicates a lack of interest in evaluation by nurses or whether it suggests that procedures exist on paper but not in practice. Further investigation would be required to answer this question.

How were the results of evaluations used?

The evaluation results were used to provide feedback to nurses about performance in 90.9% of the reporting health units. Some attention was given to the task of individual professional development through procedural components requesting:

1) a listing of workshops attended;
2) personal goals for the next six months; and
3) career plans.

Some verbal attention was paid by Supervisors to the possibility of improving staff-supervisor relations as well as to the assignment of nursing activities based on nursing strengths.

While nurses did conclude that evaluations were used to provide feedback about performance, several nurses expressed feelings that results were "kept on file" or that they "had never seen the official results" and "supposed they were in their file."

Board Members suggested that results might be used where a nurse's position "was to be terminated" or as "a basis for references following termination."

Use of evaluative results was not consistent among health units. An assumption was made that results could be used to provide feedback to the nurse about performance, but comments suggested a more routine use was for "file purposes." The implied lack of interest expressed with evaluation results and the hope, rather than assurity, that results could be used as a "teaching tool" or to "improve supervisor/staff relations" might suggest that results are not currently put to significant use. One wonders, then, about the use of present evaluation procedures as a means of providing significant results capable of achieving these desired aims.

What degree of acceptance was present with the methodology and usage by identified stakeholder groups?

Supervisors, as a group, expressed some concern over the methods used, suggested that methods were under review, and expressed hope that some guidelines could be provided on a provincial basis for staff nurse evaluation.

Nurses, as a group, expressed an acceptance of the method used and of the usage of the results. While some dissatisfaction was evident in their comments, a blanket acceptance of the need for evaluative methods was maintained. Some suggestions were made that evaluative results be used for teaching purposes and for the assignment of work loads.

Board Members, again, provided unanimous support for the present system of evaluation "whatever it was."

The acceptance of current evaluation procedures despite voiced concern as to their effectiveness suggests a laissez-faire attitude by stakeholders to community health nursing evaluation. Change generally occurs when dissatisfaction exists with the status quo. Is such blanket acceptance an indication of futility in implementing change? Of an inability to address the problem? Of apathy? Or is the current state of affairs reasonable given the situation?

What degree of satisfaction was experienced by stakeholder groups with respect to the *present evaluative process?*

Stakeholders collectively presented a moderate level of expressed satisfaction with the methods of evaluation used. Supervisors consistently rated the methods higher than staff nurses. Board Members were non-committal in their ratings of the evaluative procedures claiming that the procedures used "must be satisfactory" to meet the needs of the agency. Participants in the second round agreed with the moderate to slightly dissatisfied rating of evaluative methods, expressing views that what they "have was better than what they had in the past but could be improved." The expressed ratings of satisfaction follow the blanket acceptance of the evaluation processes. Moderate satisfaction does not commit the individual to any direction; procedures are viewed as neither bad enough to warrant immediate attention nor good enough to prevent interested individuals from examining the issue. This stance tends to weaken the impetus for change and makes outside investigation of the problem more plausible; power-coercive strategies tend to be used most effectively in this case.

What expectations are held by the stakeholder groups as to the necessity for, usage of, and types of methods employed in the evaluation of community health nurses?

All stakeholders viewed evaluation of community health nurses as a necessary and potentially useful procedure. Results were used for performance feedback and retained on file. Nurses and Supervisors envisaged greater use for teaching and professional development.

When asked to identify ideal or desired methods of evaluation, nurses identified peer review, client survey, self-evaluation, and document review as potential sources of evaluative information. A generalized attempt to extend the data base for evaluation while retaining the supervisor responsibility for evaluation seemed evident.

Supervisors retained faith in the supervisor evaluation but granted credence to the use of self-evaluation and a management by objectives approach to evaluation.

Board Members indicated faith in general evaluations accepted by staff and Supervisors. Two individuals mentioned a desire to be more aware of the practices used but all Board Members indicated a lack of desire to become actively involved in evaluations.

Participants in the second round, on examining the findings, expressed a belief that evaluation should involve a number of data sources rather than any one in particular.

The expectations for evaluation in the future did not reveal any dramatic departure from present procedures. A desire was expressed by nurses to broaden the data base of current evaluations but no creative suggestions were made as to how this could be accomplished realistically. Supervisors were allocated responsibility for such evaluations despite an acknowledgement that alternative areas needed to be examined such as peer and client review.

B. Community Health Nursing Competencies

What competencies are considered necessary for successful performance in the position of community health nurse?

By using an 80% agreement on individual competencies as a criterion for validation, 45 competencies were considered necessary for successful performance in the position of community health nurse.

The following competencies were validated in the second round:

Personal beliefs and attitudes:

1. Positive attitude toward self and others
2. Client centered orientation and family centered service
3. Preventive orientation

Personal Traits and Characteristics:

1. Self-assurance
2. Consistency
3. Common sense
4. Enthusiam
5. Versatility
6. Empathy
7. Consideration

Technical Skills:

1. Writing and recording skills
2. Screening and associated equipment skills

3. Nursing procedures
4. Immunization skills

Direct Interaction with Clients:

1. Observation skills
2. Counselling skills
3. Interviewing skills
4. Communication skills
5. Assessment skills
6. Teaching skills

Personal Skills:

1. Resourcefulness as a skill
2. Maintaining confidentiality
3. Personal coping ability
4. Responsibility in the nursing situation
5. Decision making skills
6. Ability to act independently
7. Adaptability to changes in the work setting
8. Ability to maintain competence
9. Objectivity

Administration System Skills:

1. Public relations skills
2. Evaluation skills
3. Ability to work within system policies
4. Ability to work as a team member
5. Knowledge and use of community resources
6. Organizational skills
7. Planning long range care
8. Establishing and utilizing a referral system

Knowledge:

1. Sexuality
2. Gerontology

3. Immunology
4. Group dynamics
5. Nutrition
6. Epidemiology
7. Growth and development
8. Maternal and child health

Lack of validation does not necessarily indicate that the competency in question was not necessary to community health nurse performance, but rather that some concern existed with the competency as presented. Personal traits and characteristics was disclaimed categorically as a requirement for competence but special notation was made that such personality attributes must be considered in nurse selection and assignment to a nursing area. Several attributes were validated despite this categorical denunciation; practice did not follow thought. Perhaps this is a problem with evaluation as it now exists: practice does not follow theory nor beliefs as to what should or could be accomplished given adequate resources.

Nurses stressed operational competencies of immunization skills, interpersonal relationship skills, communication skills, assessment skills, teaching skills, ability to work as a team member, knowledge and use of community resources, organizational skills, knowledge of growth and development and nursing education.

Supervisors emphasized a greater number of competencies including enthusiam, versatility, screening skills, nursing procedures, communication skills, assessment skills, teaching skills, ability to act independently, adaptability to changes in the work setting, ability to maintain competence, evaluation skills, knowledge and use of community resources, and nursing education. These competencies appear to reflect a desire for an independent practitioner able to organize and perform capably in an area without intense supervision.

Board Members identified relatively few competencies and showed less group agreement on those competencies. Those competencies achieving a 25% agreement or more included preventive orientation, interpersonal relationship skills, ability to work within system policies, previous experience and nursing education. All these competencies would fit the public image of preventive care and provide an individual capable of working within the system and not causing "difficulties."

The choice of emphasis allocated by stakeholders to competencies seems reasonable on examination. Nurses noted those competencies which would assist them in their daily activities; Supervisors noted those that would ensure a qualified independent staff member that could accomplish the assigned work; Board Members noted those that ensured staff compliance to system requirements. These differences in priorities must necessarily be reflected in the design of an evaluation program and in the usage of the results. The main question, then, becomes: what is the purpose of evaluation? Who decides?

What criteria might be used to measure such competencies?

Respondents in both rounds were requested to suggest criteria that might be used to measure each competency. This appeared to be the most difficult task presented to the respondents. First round participants tended to suggest sources for evaluative data rather than particular behaviors that could be assessed to indicate the level of performance of a particular competency. Second round participants followed suit although more specific detail was suggested and no competency was left without some "suggestions for measurement."

No difference was noted among stakeholder groups in their ability and/or willingness to suggest some source of evaluative data. Strong reliance appeared to be placed on observation by Supervisors (usually with no supplementary behavioral criteria), record review, client survey, self-evaluation, and peer review. While respondents found criteria within these sources difficult to identify, there appeared to be abounding faith that such criteria could be developed in a joint effort by nurses and Supervisors. One wonders if such a task is recognized as important and manageable, why such attempts seem to have failed in the past?

Can these competencies be ranked in importance? If competencies could be ranked, what ranking was obtained? What was the significance of that ranking?

Despite statements to the contrary, most respondents in round one attempted to rank the competencies identified. Those given an average rank of between 1 and 1.9

included: self-assurance, empathy, versatility, interviewing skills, decision making skills, knowledge of immunology, nursing education, interpersonal relationship skills, ability to maintain competence, adaptability to change, knowledge and use of community resources, preventive orientation and communication skills. It is interesting to note that those competencies receiving a perceived significance in ranking embody those competencies most frequently identified.

Both respondents in the first and second round noted the overlap and interplay of competencies. It would appear that priorities can be set as to necessary competencies but only when done in an isolated situational context. Setting priorities among competencies as universals proved possibly detrimental when attempting to treat each client individually and allowing nurses uniqueness in their response.

C. Differences From Other Settings

An interesting byproduct in the discussion of competencies was the differentiation between community health nursing and other nursing practice areas. Those statements validated through group consensus in the second round included those in which the community health nurse

1. must work independently with less backup and less direction
2. assists clients to help themselves rather than doing for the client
3. uses a community orientation to illness rather than an individual patient outlook
4. works with "well" people as opposed to "sick"
5. must assess the community and be aware of its resources
6. operates under a preventive rather than a curative orientation
7. requires driving skills
8. offers non-compulsory services as opposed to compulsory services to a captive clientele in the hospital
9. initiates care as opposed to following through on orders

This listing, in itself, might identify some priorities in competencies for community health nursing. The differences, however, must be examined in greater detail to ascertain if they do indeed exist. If so, the finer details of the competencies must be translated into criteria for measurement. If not, the perceptions of the differences should be examined.

What is the reaction of the stakeholder groups to the use of competencies to form the basis of an evaluation?

All respondents involved in the study expressed belief in the possibility that competencies, once identified as unique and/or applicable to the community health setting, could be successfully used as the basis for an evaluation.

An assumption appeared to be made that evaluation was to be completed on a "standards for excellence approach" rather than on a "minimal standards for competence approach."

The willingness to undertake the task of competency identification and validation and the efforts made by second round participants in applying such competencies to community health nurse evaluation was both rewarding and inferred some commitment to competency based evaluation.

What is the reaction of stakeholder groups to the use of the AARN Nursing Practice Standards in evaluation?

Respondents in the second round acknowledged the use of the nursing process in community health nursing. Conflict emerged when respondents attempted to directly apply the nursing process as a method of evaluating an individual staff nurse. Greater success was anticipated by those respondents when the use of these standards was applied to the evaluation of community health programs.

Respondents were able to assign study competencies to each standard in an attempt to combine a competency based approach to individual nurse evaluation with the more general nursing practice standards. The group consensus, on completion of this task, was that further work needed to be directed to making both the competencies and the standards unique to the community health nursing setting. Again, faith was expressed that such a direction was both desirable and manageable.

D. Reflections

Community Health Nursing System

The respondents were involved in the initial stages of an evaluative process. The field seems to reflect the community health nursing system portrayed in chapter three. Board Members, however, do not seem to exert a strong influence within the system when considering the issue of evaluation. While possibly influencing the policy decisions made about the existence of evaluation within a health unit, Board Members cannot be considered core stakeholders actively involved in the evaluation of community health nurses; they at best hold a peripheral position.

Board Members were not aware of the details of the evaluation programs employed within their health units, but reported assurance that such procedures not only were "carried out," but were also suitable to the needs of the health unit. Should Board Members be more actively involved? Is it reasonable for them to be allocated that responsibility? If these individuals do indeed reflect the beliefs/needs of their communities, then it follows that they reflect the beliefs and desires of health care consumers. The literature supports and indeed contends that consumers should be included in the design, implemetation and evaluation of health care; governments are attempting to facilitate this inclusion. Perhaps if consumers are to be involved in the evaluation of services, an examination should be made as to their qualifications for that responsibility and their abilities and desires to undertake that task. Or, should the task be allocated merely on the basis of being a consumer?

Evaluation

The literature supports the necessity for a common perception of the evaluative process by the stakeholders. Evaluation occurs in situations where people make choices about alternatives, the worth of each alternative determined through systematic efforts to define and understand it.

Findings in this study suggest a number of alternatives. A common perception exists that competency evaluation provides an accurate data base for assessment and that this direction is acceptable to stakeholders. What remains to be done is the design of the evaluation plan. Should the AARN program be implemented as proposed? Findings suggest that while the program might be applicable, it has shortcomings. Can these be overcome? Can standards be made to reflect the uniqueness of the setting?

Using a Stake approach to evaluation, the intents of practice can be identified through the perceptions of those individuals providing the service. Standards, such as those provided in the AARN program, exist by which to judge intents. Further investigation must be directed to the observation of those intents. The competencies validated in this study indicate a focus for those observations. Judgments made regarding the existence of these competencies might also reveal competency levels. By validating the competencies in the field and generating measurement criteria acceptable to field respondents, an assurance is given that criteria for evaluation will not be judged trivial, that they will be relevant, reliable, objective and practical.

Change

Is nursing, and particularly community health nursing, undergoing change? Chaska (1978:373) contends that the nursing profession as an entity is experiencing a period of intense change; this is indicated by expanded role practice, quality assurance programs, primary nursing evolvement and specialty education programs. Nursing is thought to be actively demonstrating its part in improving health care by assuming responsibility to shape its own future through planned change.

Within the system, attempts (including this study), have been made to identify the specific problems and perspectives of stakeholders as they apply to nurse evaluation. Most attempts have had limited and temporary success. Respondents are wary of yet "another study"; they do, however, continue to participate in hopes that "something will come out of it."

This study has increased the awareness of role expectations and evaluation issues among three groups of health professionals in the community health arena. The study provides a direction for stakeholders by:

1) providing a preparatory workup for eventual AARN program criteria development;
2) sensitizing the field to the potential concerns that might develop if a single evaluation program is utilized for both hospital and community health nurses;
3) providing information that might suggest alternative strategies for

evaluation more suited to the needs of community health nurses; and

4) increasing the awareness of stakeholders as to the problems experienced by their counterparts in developing evaluation programs.

The readiness of field practitioners to be involved in change was evident in this study by their willingness to cooperate and to critically address the issue of evaluation. These characteristics, generally, might suggest the use of either normative-reeducative or empirical-rational strategies for implementing changes in the evaluation programs. A normative-reeducative strategy was employed as part of the study by involving those parties most influenced by the outcome of the evaluative process and by gaining their perceptions on the problems of evaluation. By their involvement in the study, and the acceptance of the problem as their own, the pressure to change and the impetus to continue the process appears to have occurred. The researcher has assumed, on completion of the study, an empirical rational strategy for change, assuming that the field (in particular nurses and Supervisors) once made aware of the factors involved in evaluation and the possibilities for developing a competency based evaluative procedure will make further efforts in that direction.

The findings suggest a wealth of resources within the system suited to the problem of developing an evaluation program. Health units, and the individuals within them, have provided evidence, through their responses to the task, of varying levels of expertise and established practices for CHN evaluation. These leads need to be followed up and a data bank established on a provincial basis as to the programs presently in use and their reported effectiveness. By examining these resources, health unit personnel can home in on those most relevant to their situation. Considerable savings could be made by preventing serious duplication of efforts by individuals who do not, by their own admission, have unlimited time to direct to evaluation.

How can the results of this study be used? Findings suggest a direction toward the further identification of competencies within the community health area, a verification of these competencies through observation, and a choice of evaluation procedures applicable to the measurement of these competencies. The problem has not been solved. Stakeholders have begun to define their problem in evaluation and have begun to identify resources. They must continue the process, however, and enter the third and fourth stages of Havelock's problem solving process.

Politics

Is community health nursing a unique entity within the nursing profession? Or is it merely a subset of the larger profession of nursing? Are the competencies required by CHNs unique? Study findings would suggest that, while minor exceptions exist as to the skill level necessary, the same competencies are required by all nurses. However, the application of these competencies may indeed vary from one practice area to the next.

While differences between community health nursing and other practice areas were perceived, there was only speculative agreement on those differences. Are they accurate? Are similar differences perceived by nurses working in other practice areas?

The issue of differences and setting uniqueness must be examined. Depending on the findings, and on the intensity of the feelings about the findings, speculations can be raised regarding the need for interest articulation and aggregation. If community health nurses are truly different, are their interests represented in the provincial associations? In the federal associations? What structures exist to ensure that articulation? Is there a need for aggregation? How political is change within the community health arena? Who are the main characters? The ramifications of the community health nursing subset status in a larger nursing profession could have involved discord, separation, and the aggregate formation in an attempt to articulate community health interests.

However, while community health nurses view their practice as having unique characteristics, strong identification was maintained with the nursing profession as a whole. Until further work is done in the area of defining the uniqueness of community health nursing and attempting to disseminate the knowledge of that uniqueness, motivation to interest articulation and aggregation remains minimal.

Goals

How are goals set within the community health system? While some efforts seem to exist independently within the health units to set and define goals for evaluation, attempts to consolidate these goal directions have been noted only recently. Indications of common goals and emphasis are noted in the inservice programs for Supervisors (Evaluations Perspective 1981) and the common grievance noted in the study regarding the limitations of existing evaluative programs.

Other than on an informal basis, how the goals for evaluation are set within the CHN system remains unclear. An implication can be made from the respondents' willingness to cooperate that goal setting is best accomplished using a significant group approach. Further examination must be made into the mechanisms of the process and the implication of group development for policy decisions and longtem acceptance of innovations.

E. Summary

The problems of the study and the questions arising from those problems were addressed individually by examining the results presented in chapters five and six. The significance of the findings were speculated upon while the literature related to this thesis and the conceptual framework were the subjects of reflection.

The state of community health nursing evaluation must be considered immature in its development in light of the lack of consistency in evaluation methods across the surveyed health units and the lack of theoretical application to those methods. Respondents, however, were both cooperative and knowledgeable regarding the competencies which might be required of CHNs and methods of evaluation which might be used to measure those competencies.

VIII. SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS FOR FURTHER STUDY

In this chapter, the study is reviewed, conclusions derived from the findings, implications drawn for nursing practice and recommendations suggested for future study.

A. Summary

The purpose of this study was to investigate the perceptions of community health nursing stakeholders toward the evaluation of competencies of community health nurses as employed in Alberta health units. An attempt was also made to investigate how these perceptions might apply to the AARN Nursing Practice Standards as a program of evaluation.

As evaluation was of interest in the nursing profession at the time of the study, the involvement of stakeholders in a description of the state of affairs of community health nurse evaluation in health units in the province of Alberta seemed both timely and necessary.

The study was completed in two stages. The first round involved Board Members, Nursing Supervisors, and staff nurses from eleven health units. Respondents were requested to generate nursing competencies, reflect on present methods of evaluation, and speculate on ideal methods to evaluate staff nurses. Findings from the first round were presented to staff nurses and Nursing Supervisors in eleven health units in a second round of data collection. Respondents were requested to validate round one findings and speculate on the use of the AARN Nursing Practice Standards and identified competencies in community health nurse evaluation.

Several methods of data collection were employed in an attempt to increase the richness of the data obtained, and to increase the exposure of the health unit sample to the study. Tape recorded interviews, mail questionnaires and document review were used in the first round; group interviews and mail questionnaires were used in the second round. Content analysis and descriptive statistics were used to analyze the data.

B. Conclusions

Based on the literature and in the light of the discussion of findings presented in chapter seven, the following conclusions are made with further speculation made as to their significance:

1) It was found that competencies for practice could be identified within the community health nursing practice area.

2) Some differences existed among stakeholders in their perceptions of the competencies necessary for community health nurse practice. Nurses noted operational competencies, Nursing Supervisors noted administrative task competencies and Board Members noted system competencies. Some differences were noted in the ability of stakeholders to generate competencies; Board Members were less able to list competencies for practice than were either nurses or Nursing Supervisors. Such differences, however, may reflect the stakeholders' ability to generate competencies rather than a true perception of the range of competencies necessary for practice. This speculation is born out by second round findings: the list of competencies which was generated in the first round of data collection received general agreement in the second.

3) The extent of agreement with most of the competencies implies that it would be possible to develop a set of competencies acceptable to nurses and Supervisors for the evaluation of staff nurses.

4) Findings in round one imply that Board Members were unaware of the range of community health nursing competencies and of the methods of evaluation used for assessing staff nurse performance. An assumption was made by Board Members that evaluation was not only carried out , but that it was appropriate to the needs of the health unit. In most instances this assumption was justified. However, it is important to note that this assumption was based on blind faith rather than written formalized expectations. Can such an assumption be made and/or continued in light of the current consumer demands for professional

accountability?

Board Members, as elected officials, are supposed to reflect the communities they represent. If their knowledge of community health nursing is typical of the public at large or health consumers, one wonders about the current responsibility placed on consumers to identify the direction of health care service. Perhaps a public education program might be adviseable. To do this, however, community health nurses must first identify and understand their own field of practice and the competencies it commands.

5) A perception exists within the stakeholder groups that community health nursing practice differs from that of other nursing practice areas. The exact nature of the difference has not yet been determined but might be inferred from the statements receiving validation in the second round. The accuracy and the intensity of the perceived differences must be ascertained before speculations can be entertained in the directions of requirements for interest articulation and aggregation.

6) No one method was used provincially for the evaluation of community health nurses. The method most commonly used was supervisor observation. With no provincially accepted method of evaluation, employee tranference from one health unit to another does not include evaluation reports that could shed light on the appropriateness of the individual nurse for the new position. Common criteria and methodology would not only influence nurse selection but could also influence preservice educational requirements.

7) Evaluative procedures having a broader data base were desired by nurses. Specification of such data sources included peer review, client survey and document review. While feedback from peers and clients may seem positive when provided informally, the requirements of a formalized procedure may change the nature of this feedback and the responsibility of those persons giving this feedback. Are nurses willing to accept this change? Are consumers?

8) Nursing Supervisors reported slightly more satisfaction with individual evaluative procedures than did nurses; all Supervisors indicated general dissatisfaction with their evaluation programs and as a result indicated plans to revise methods currently in use.

9) Competency-based evaluations were perceived as applicable for use within the community health practice area.

10) A willingness existed among Nursing Supervisors and staff nurses to pursue the use of the AARN Nursing Practice Standards as a method of evaluation in community health practice; they were unsure of the application to their programs or their individual performance.

C. Implications for Nursing Practice

The following implications are made for nursing practice:

1) The assumption that effective CHN skills can be fully identified at this time is not supported by the outcome of this study. It is premature to allege prescriptions for CHN competencies. Practical field knowledge for community health practice is stronger than the research knowledge at its base. What has been gained from this study is a rudimentary picture of community health nursing practice with some indication of the complexities of the nursing practice process.

2) Competencies have not been stated specifically in behavioral terms yet cannot be stated as simple generalizations. To accurately identify the practice setting, and the possibilities of variations within it, its contexts, and clients, more refined research efforts must be undertaken. Until such research is undertaken, evaluative programs will look good on paper but will not be proven in practice. Criteria need to be relevant, realistic, objective and practical. The best theoretical evaluation program will fail if criteria do not have these characteristics.

3) Priorities need to be established regarding the applicability of competencies to the greatest number of settings and recognizability of effecting outcomes. It appears that the current state of knowledge in

community health nursing has been more productive in pointing out new directions for research rather than for immediate transfer to the work setting.

Once priorities are established, decisions can be made as to which competencies constitute core skills. Once identified, those core skills can be compared to core skills required by nurses in other practice areas.

4) The information provided by this study may be useful in developing
   a) a description of task-on competencies of community health nurses for the purpose of community health nurse evaluation;
   b) a CHN job description;
   c) a rationale and criteria for CHN selection;
   d) an inservice program for stakeholders to address the issues of evaluation, competency-based evaluation, and the differences perceived to exist between community health and alternate practice areas.
5) The willingness of nursing stakeholders to cooperate in this study, and the expertise they showed in the fulfilment of that task, suggests that future activities could be completed in-house. Studies should be completed on a provincial basis to use the talents and energies of the persons involved, and interested.

D. Recommendations for Further Study

Based on the conclusions and implications presented, the following recommendations are made for further study:

1) Findings suggest that additional criteria can be established for staff nurse evaluation. A study could be conducted to establish such criteria and to develop a rank order of the importance of these criteria in nurse evaluation.
2) Ideally research could build a data base upon which CHNs could draw for decision making. This must be built by individuals committed to research

rather than advocacy and who take into account all factors involved in the conceptualization of community health nursing as it really is and might be.

3) It is important to recognize nursing competencies as independent variables affecting client outcomes. Research into the optimal levels of nursing behavior producing optimal levels of growth is necessary to refine competencies to the extent that mastery levels might be determined.

4) Ideally research into competency based evaluation could reflect on the adequacy of preservice and inservice educational programs. It is suggested that practical research into these applications, possibly using a QAM technique (Sanders, 1980), might be beneficial.

5) The perception that community health nursing constitutes a unique practice arena complete with competencies specific to that setting must be examined further in the light of the need for interest articulation and aggregation. A study into the political system operating in community health nursing and the identification of the structures supporting that system seems desirable.

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Appendix A - Pilot Interview Schedule

COMMUNITY HEALTH NURSE EVALUATION

Sample Identification:

Category:

1) Board Member ....(__)
2) Supervisor..........(__)
3) Staff Nurse.......(__)

Duration of Position:

1) How long have you worked in this position?......(_____years)
2) How long have you worked in community health?....(_______years)

What competencies are presently necessary for successful performance in the position of community health nurse?

Can the competencies you have identified be ranked in terms of importance?

Are these competencies different from those required of nurses not working in community health? How? Why?

What criteria might be used to measure these competencies?

What methods of evaluation are presently used in this health unit for the position of community health nurse? Describe

What do you think of the present methods? Agree with? Accept?

What use is made of the results of the present evaluation?

How satisfied are you with the present method of evaluation: On a scale of 1 to 5 where 1 indicates high dissatisfaction and 5 represents high satisfaction, where would you place yourself?

The following questions are directed toward the ideal situation – what would you like to see.

What competencies do you think the ideal community health nurse should have?

Can these competencies be ranked in terms of importance?

What criteria might be used to measure such competencies?

What method of evaluation would you like to see implemented for the position of community health nurse?

Appendix B - Revised Interview Schedule

COMMUNITY HEALTH NURSE EVALUATION

Sample Identification:

Category:

1) Board member............(__)
2) Supervisor.................(__)
3) Staff nurse...............(__)

Duration of Position:

1) How long have you worked in this position?.....(__years);
2) How long have you worked in community health?.....(__years)

What competencies are presently necessary for successful performance in the position of community health nurse?

Can the competencies you have identified be ranked in terms of importance? If so, list in order of importance.

Are these competencies different from those required of nurses not working in community health? How? Why?

What criteria might be used to measure each of these identified competencies?

What method(s) of evaluation is(are) presently used in this health unit for the position of community health nurse? Describe

What use is made of the results of the present evaluation?

How satisfied are you with the present method of evaluation -- on a scale of 1 to 5, where 1 indicates high dissatisfaction and 5 represents high satisfaction, where would you place yourself?Why?

Is there such a person as an ideal community health nurse? Are there any ideal competencies that you would like to see?

What method of evaluation would you like to see implemented for the position of community health nurse?

Appendix C - Repondent Questionnaire

RESPONDENT QUESTIONNAIRE

Circle the number which best represents your reaction to the following statements.

1 – strongly agree

2 – agree

3 – disagree

4 – strongly disagree

5 – do not know or no opinion

1. I understood all the questions.

   1 2 3 4 5

2. My answers were frank.

   1 2 3 4 5

3. The questions were biased.

   1 2 3 4 5

4. The interviewer appeared to be neutral.

   1 2 3 4 5

5. The questions were adequate to cover the variables and issues in community health nurse evaluation.

   1 2 3 4 5

6. I answered each question as honestly as possible.

   1 2 3 4 5

7. The interviewer suggested a particular point of view.

   1 2 3 4 5

8. Other respondents will interpret the questions the same way I did.

1 2 3 4 5

9. The interview gave me ample opportunity to express my perspective on community health nurse evaluation.

1 2 3 4 5

10. The questions were fair and free from prejudice.

1 2 3 4 5

Appendix D - Letter to Evaluation Class

EVALUATION 515 CLASS

The attached questionnaires are to be administered in a pilot study. The questionnaire titled "Interview -- Community Health Nurse Evaluation" is to be used as a semi-structured interview. The purpose of the interview is to collect information on the perspectives of stakeholder groups regarding community health nursing competencies and methodologies for evaluation.

The second questionnaire titled "Respondent Questionnaire" is to be administered to respondents following the interview session. The purpose of this questionnaire is to ascertain whether the interview questions and/or interviewer were biased, and whether the respondent understood the questions and answered them honestly.

Please read the questions and make any comments, alterations, deletions, additions, or criticisms where appropriate on the questionnaire. If you feel the question should remain in its present form put a check in the box beside the question. Please return the questionnaire to Sandy Tenove (located in the lab) by noon today.

Appendix E - Pilot Study Evaluation Team

The Evaluation Team

The Evaluation Team is composed of three members:

Sandra Tenove:

1) Principal researcher of the larger study;
2) Community Health Nurse 1972 to 1979;
3) Papers:
    a) "Procedures and Criteria Used by Alberta Health Units in the Selection of Community Health Nurses," an unpublished Master's Thesis, Department of Educational Administration, University of Alberta, 1980.
    b) "Competency Testing in Nursing," an unpublished monograph, January 1981
    c) "Evaluation of Nursing Performance in the Community Health Arena," an unpublished monograph, April 1981.
4) Course Work Relevant to Evaluation:
    a) Ed. Admin. 636, Organizational Effectiveness and Evaluation, Winter 1981;
    b) Ed. Admin. 691, Evaluation of Human Service Programs, an Individual Study, Winter 1981;
    c) Ed. Admin. 692, Evaluation of Human Service Personnel, an Individual Study, Winter 1981;
    d) Ed. Admin. 591, Evaluation -- the State of the Art, May 1981;
    e) Ed. Admin. 515/516, Evaluation, May 1981.
5) Research Experience:
    a) Researcher -- Master's Thesis -- involving questionnaire development and analysis;
    b) Researcher -- Practical Experience -- program evaluation in the community health field;
    c) Researcher -- Doctoral Dissertation -- involving interviewing and design development.

Cathy Campbell:

1) Course Work:
   - a) Ed. Admin. 515/516, Evaluation, Spring 1981;
   - b) Ed. Admin. 636, Organizational Effectiveness and Evaluation, Winter, 1981;

2) Research Experience:
   - a) Research Assistant to Dr. Clive A. F. Padfield -- involving a survey questionnaire;
   - b) Researcher -- Master's Thesis -- involving observer training, observation, questionnaires, and analysis;
   - c) Research Assistant to Dr. D. Sande -- involving document analysis;
   - d) Researcher -- Doctoral Dissertation -- involving observation and interviewing.

Colla MacDonald:

1) Course Work:
   - a) Ed. Admin. 515, Evaluation, Spring 1981;

2) Research Experience:
   - a) Practical Experience -- internal program evaluation in the teaching field;
   - b) Practical Experience-- questionnaire respondent perspective;

The rationale behind the composition of the research team allowed for the ability of the nurse to indicate the practical significance of the study to the field and to control the focus of the evaluative efforts through the ownership of the larger study. The non-nurse members were chosen to allow outside input into the nursing study thereby controlling bias. Because of the research and evaluation experience of these members, their perspectives and input to the study is considered invaluable.

Appendix F - First Round Participation Letter

June 16, 1981

Dear ______________________;

Your assistance is requested in a research study I am conducting as a doctoral candidate in the Department of Educational Administration at the University of Alberta.

The purpose of this study is to gain the perspectives of community health nurses, Nursing Supervisors, and members of the Local Health Authority on community health nurse evaluation.

Perspectives on the following issues will be ascertained: community health nursing competencies, methods of evaluation, response to evaluation, and criteria for measuring competencies. Both the present and the ideal situations will be included. Interviews of about 1/2 to 3/4 hour in length will be used to gain this information.

This study will be a supplement to a program presently being undertaken by the AARN to examine nursing practice standards and to set standards and competencies applicable to all practice areas.

If you would be willing to have your health unit involved in this study I would appreciate your assistance in arranging interview times with:

1) 2 Board Members;
2) yourself as the Nursing Supervisor; and
3) as many community health staff nurses as available.

To facilitate this procedure, could you complete the enclosed appointment form and return it as soon as possible in the self-addressed envelope.

Your cooperation in this study is most appreciated. Health units have been assigned randomly to a first or second round of data collection and I hope that you will be able to meet the constraints imposed by the other study by being included in this summer's efforts. Should you have any questions, please feel free to contact me at the same address or by phone at 433-5664. Copies of the overall research proposal are available for review on request.

For those who have not already received a copy of the results of the study completed in 1980 on community health nurse selection in Alberta, a copy of the findings and recommendations is enclosed. Complete copies of this study are available through the University libraries, the Faculty of Nursing, the AARN, and myself (at cost-- $12.00).

Your sincerely,

Sandra Tenove,
Doctoral Candidate,
Department of Educational Administration,
University of Alberta

Appendix G - Letter to Board Members

11708-83 Avenue,
Edmonton, Alberta,
October 7, 1981

Chairman of the Board,
__________ Health Unit,
____
__________, Alberta
____

Dear Sir;

I am presently undertaking a study on the evaluation of community health staff nurses as part of a doctoral studies program at the University of Alberta.

This study investigates the evaluation of community health staff nurses and wishes to identify the present and ideal competencies of these nurses from the perspectives of Board Members, Nursing Supervisors, and the community health nurses themselves.

Board Members have been included as an integral part of the study for several reasons. As elected officials, you can be considered important consumers of community health services; as Board Members, you also have input into the policies and financial management of the Health Unit and its programs. Overall, your views as to what should be considered as community health nurse competencies are very important.

I seek your assistance in requesting the participation of two Board Members, the individuals to be selected by yourselves. These two persons will be asked to complete the attached questionnaires concerning competencies, criteria for measurement, evaluation methods, and associated satisfaction. It is expected that this questionnaire will take one half hour or less to complete. I might add that your first reactions are generally the most helpful.

It is my hope that you will agree to participate in this study. Results gained will be helpful to the community health nursing departments in meeting the demands of the AARN evaluation program scheduled for the spring of 1982 and to the administrative structure of the Health Unit in general in handling the pressures surrounding employee evaluation.

In the event that you agree to participate, a return envelope has been included with the questionnaires. If possible, the questionnaires should be reurned no later than November 15, 1981. Thank you for considering this request. I look forward to your reply.

Sincerely,

Sandra Tenove
Doctoral Candidate

The above study has the support of the Department of Educational Administration, University of Alberta.

Dr. R. Bryce,
Advisor,
Department of Educational Administration,
University of Alberta

Appendix H - Local Health Authority Questionnaire

LOCAL HEALTH AUTHORITY QUESTIONNAIRE

So that all respondents will begin with the same understanding, the following definitions are offered for clarification. It may be helpful to keep these definitions accessible while answering the questions:

Evaluation -- the process of delineating, obtaining, and providing useful information for judging decision alternatives (Worthern & Sanders, 1976:129).

Competence -- the quality or state of being functionally adequate or of having sufficient knowledge, judgment, skill, or strength (Schneider, 1979:1).

Competency -- An intellectual, attitudinal and/or motor capability derived from a specified role and setting, and stated in terms of performance as a broad class or domain of behavior (Peterson 1978:3). For the purposes of this study, competency will be operationally defined as those characteristics (knowledge, attitudes, or ways of doing things) that a community health nurse must have to be considered 'competent' in his/her job.

Criteria __ For the purposes of this study, criteria will be operationally defined as standards or guidelines that can be used to measure a specific competency.

What competencies do you think are necessary for a community health nurse to be considered a success in his/her position? Please list as many as you can think of.

Can the competencies you have identified be ranked in terms of importance? If so, number in order of importance on the first page beside each of the identified competencies.

If not, why not?

Do you think the nurses in your health unit have these competencies? Yes ______ No______.

Do you think the nurses in your health unit use these competencies? Yes ________ No __________.

If not, which competencies do you think are not commonly used?

Are these competencies different from those required of nurses not working in community health (For example, those nurses working in a hospital)? How? Why?

What criteria might be used to measure each of these identified competencies? Use as many of the following spaces as are required. Use the back of these pages if more space is required.

Competency 1: ______________________________

How this can be measured or evaluated?:

Competency 2: ______________________________

How this can be measured or evaluated?:

Competency 3: ______________________________

How this can be measured or evaluated?:

Competency 4: ______________________________

How this can be measured or evaluated?:

Competency 5: ______________________________

How this can be measured or evaluated?:

Competency 6:______________________________

How this can be measured or evaluated?:

Competency 7: __________________________

How this can be measured or evaluated?:

Competency 8:______________________________

How this can be measured or evaluated?:

Competency 9:______________________________

How this can be measured or evaluated?:

Competency 10:______________________________

How can this be measured or evaluated?:

Are you familiar with the method of evaluation used in this health unit for the position of community health staff nurse? Yes ________ No __________.

If yes, please describe the method used:

What use is made of the results of the present evaluation?

How satisfied are you with the present method of evaluation -- on a scale of 1 to 5, where 1 indicates high dissatisfaction and 5 represents high satisfaction, where would you place yourself? Why?

Rating of Satisfaction: ______________;

Explanation:

If you could have a choice, is there a method of evaluation you would like to see implemented for the position of community health staff nurse? If so, please describe.

1

Do you have any active involvement in the evaluation of community health nurses? Yes ________ *No* __________.

If yes, please describe your role:

Do you think that Board Members should have a more active role in the evaluation of community health nurses? Yes ______ *No* ______.

If yes, please describe the preferred role:

Do you have any comments/suggestions regarding the evaluation of community health nurses? . . . about this study?

Appendix I - Community Health Staff Nurse Questionnaire

COMMUNITY HEALTH STAFF NURSE QUESTIONNAIRE

This study concerns the evaluation of community health staff nurses and wishes to identify the present and ideal competencies of these nurses from the perspectives of Board Members, nursing Supervisors, and the community health nurses themselves.

You are asked to complete the following questionnaire concerning competencies, criteria for measurement, evaluation methods, and satisfaction with the latter. It is expected that this questionnaire will take about one half hour to complete. Your first reactions are generally the most helpful.

So that all respondents will begin with the same understanding, the following definitions are offered for clarification. It may be helpful to keep these definitions accessible while answering the questions:

Evaluation -- the process of delineating, obtaining, and providing useful information for judging decision alternatives (Worthern & Sanders, 1976:129).

Competence -- the quality or state of being functionally adequate or of having sufficient knowledge, judgment, skill, or strength (Schneider, 1979:1).

Competency -- An intellectual, attitudinal and/or motor capability derived from a specified role and setting, and stated in terms of performance as a broad class or domain of behavior (Peterson 1978:3). For the purposes of this study, competency will be operationally defined as those things that a community health nurse must be able to do to be considered 'competent' in his/her job.

Criteria -- For the purposes of this study, criteria will be considered to be those standards, guidekines or measures by which one could evaluate the identified competency.

Thank you in advance for taking the time to complete this questionnaire. As the researcher, I will be visiting the health unit in the near future to gain further information and to clarify any concerns with the study.

What competencies are presently necessary for successful performance in the position of community health nurse? Please list as many as you can think of.

Can the competencies you have identified be ranked in terms of importance? If so, number in order of importance on the first page beside each of the identified competencies.

If not, why not?

Are these competencies required in your present position? If not, why not?

Do you utilize all these competencies in your present position? If not, which competencies do you *not* use?

Are these competencies different from those required of nurses not working in community health? How? Why?

What criteria might be used to measure each of these identified competencies? Use as many of the following spaces as are required. Use the back of these pages if more space is required.

Competency 1: ______________________________

How this can be measured or evaluated?:

Competency 2: ______________________________

How this can be measured or evaluated?:

Competency 3: ______________________________

How this can be measured or evaluated?:

Competency 4: ______________________________

How this can be measured or evaluated?:

Competency 5: ______________________________

How this can be measured or evaluated?:

Competency 6:________________________________

How this can be measured or evaluated?:

Competency 7: ______________________________

How this can be measured or evaluated?:

Competency 8:________________________________

How this can be measured or evaluated?:

Competency 9:________________________________

How this can be measured or evaluated?:

Competency 10:________________________________

How can this be measured or evaluated?:

What method(s) of evaluation is(are) presently used in this health unit for the position of community health nurse? Describe

What use is made of the results of the present evaluation?

How satisfied are you with the present method of evaluation -- on a scale of 1 to 5, where 1 indicates high dissatisfaction and 5 represents high satisfaction, where would you place yourself? Why?

Rating of Satisfaction: ______________;

Explanation:

If you could have a choice, is there a method of evaluation you would like to see implemented for the position of community health staff nurse? If so, please describe.

Do you have any comments/suggestions regarding the evaluation of community health nurses? . . . about this study?

Appendix J - Scott Coefficient

SCOTT COEFFICIENT "PI"

$$Pi = \frac{Po - Pe}{100 - Pe} .$$

where:

a. Po is the percent agreement,

b. Pe is the percentage agreement expected by chance found by squaring the proportion of tallies in each category, summing over all categories and multiplying by 100.

$$Pe = 100 \sum_{i=1}^{k} Pi^2$$

where:

a. k is the number of categories,

b. Pi is the proportion of tallies falling in each category.

Scott's coefficient is the amount that two coders exceeded chance agreement divided by the amount that perfect agreement exceeds chance (Flanders, 1966:13).

Appendix K - Bulletin for Second Round

COMMUNITY HEALTH NURSE EVALUATION: THE STAKEHOLDER'S PERSPECTIVE

A DOCTORAL STUDY BY SANDRA TENOVE

This study will investigate the evaluation of community health staff nurses. It will attempt to identify the present and ideal competencies of these nurses from the perspectives of Board Members, Nursing Supervisors, and the community health nurses themselves. Additionally, the study will investigate the present methods of evaluation and the ability of the identified community health nurse competencies to fit into the Standards for Practice offered by both the AARN and the CNA.

The study has been designed in two rounds of data collection. The following Health Units -- Nursing Supervisors, Board Members, and staff nurses -- were randomly assigned to the first research phase which is near completion:

Foothills Health Unit
Mountview Health Unit
Drumheller Health Unit
Barons-Eureka-Warner Health Unit
Leduc Strathcona Health Unit
Sturgeon Health Unit
Minburn-Vermilion Health Unit
North Eastern Alberta Health Unit
Athabasca Health Unit
Calgary Local Board of Health

The second round of data collection is scheduled for November--December 1981. Participants will include Nursing Supervisors and staff nurses who will be involved in one 2-3 hour brainstorming session in which participants will be asked to react to the community health nursing competencies identified by the phase one participants. You will be asked to speculate on the appropriateness of the competencies for evaluation under the Standards for Practice.

It is hoped that this study will provide community health nurses and Supervisors with the background necessary to meet the requirements of the mandated AARN evaluation program which is scheduled in the community health arena in Spring 1982. In addition it is hoped that involvement in the study will sensitize stakeholders to the issues and the possible ramifications of evaluation to community health nursing practice.

Health Units not yet invloved will be approached in October for scheduling in the second phase. It is sincerely hoped that you will agree to be involved in this study which could provide some very practical, time-saving, and significant input into your preparations for nursing evaluation.

Proposals for the study are available on request. Inquiries should be directed to:

Sandra Tenove
11708-83 Avenue
Edmonton, Alberta
T6G 0V3

Appendix L - Second Round Participation Letter

11708-83 Avenue,
Edmonton, Alberta,
November 13, 1981

________________,
________________ Health Unit,
____________________,
__________, Alberta
____

Dear __________;

With reference to our telephone conversation of this morning, the following information may be of use.

This study will investigate the evaluation of community health staff nurses. It attempts to identify the competencies of these nurses from the perspectives of Board Members, Nursing Supervisors, and the community health nurses themselves. Additionally, the study will investigate the present methods of evaluation and the ability of the identified community health nurse competencies to fit into the Standards for Practice offered by both the AARN and the CNA.

The first phase of this study has been completed and involved the generating of competencies for community health nurses as well as speculation about the criteria that could be used to measure these competencies and a reflection on the present evaluation methods being used. Sixteen health units/centres were involved in the first phase.

You are being asked to participate in the second round of this study which has an inservice format. Nursing Supervisors and staff nurses who consent to be involved will participate in one 2-3 hour brainstorming session in which they will be asked to react to the community health nursing competencies identified by the phase one participants. You will alsobe asked to speculate on the appropriateness of the competencies for evaluation under the Standards for Practice.

It is hoped that this study will provide community health nurses and Supervisors with the background necessary to meet the requirements of the mandated AARN evaluation program which is scheduled in the community health arena in Spring 1982. In addition it is hoped that involvement in the study will sensitize community health practitioners to the issues and the possible ramifications of evaluation to community health nursing practice.

It is sincerely hoped that you will agree to be involved in this study which could provide some very practical, time-saving, and significant input into your preparations for nursing evaluation. Unfortunately some time constraints have been placed on this study. If the results are to be of the most benefit to nurses, this study must be completed by March of 1982. This means that health unit participation must be completed by January 30, 1982 at the latest. If you have any further questions or have decided upon a date and time, I can be reached at the following numbers:

Home: 433-5664, answering service available for messages
Work (Educational Administration Laboratory): 432-3297, messagescan be left as well;

Thank you in advance for considering this request.

Sincerely,

Sandra Tenove
Doctoral Candidate,
University of Alberta

Appendix M - Confirmation Letter Second Round

11708-83 Avenue,
Edmonton, Alberta,
November 30, 1981

_______________,
Nursing Supervisor,
_______ Health Unit,
_______________,
_______________, Alberta
_______,

Dear _______________,

This letter is to confirm the telephone arrangements made regarding the presentation of material from the first round of the study on the evaluation of community health staff nurses.

As planned, the presentation will be made _______________, 1981 at 1:00 p.m. at the office in _________ and will last until about 3:30 p.m. It is requested that arrangements be made by yourself for the use of an overhead projector. Nurses are also requested to bring along copies of the AARN Nursing Practice Standards if available. All other materials will be provided by myself.

Thank you for agreeing to participate in this study. I look forward to meeting you and your staff.

Sincerely,

Sandra Tenove,
Doctoral Candidate,
University of Alberta

Appendix N - Overhead Presentation Second Round

The following materials were placed on transparencies and used as the core of the presentation for the second round of data collection. They indicate the focus of the discussion and provide space for the comments of the participants.

I. DEFINITIONS

Competence will be defined as the quality or state of being functionally adequate or of having sufficient knowledge, judgment, skill, or strength (Schneider, 1979:1).

Competency will accordingly, be defined as an intellectual, attitudinal, and/or motor capability derived from a specified role and setting, and stated in terms of performance as a broad class or domain of behavior (Peterson, 1978:3). For the purposes of this exercise , competency will be operationally defined as those characteristics (knowledge, attitudes, or ways of doing) that a community health nurse must have to be considered *competent* in his/her job.

Criteria will be operationally defined as standards or guidelines that can be used to measure a specific competency.

II. COMPETENCY LISTING

Competency:Category A -- Personal Beliefs and Attitudes

Reaction:

Agree? ----------------

Disagree? ----------------

Discussion:

Findings:

A. Personal beliefs and attitudes

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Positive attitude toward self and others	6	5.45	2	12.50	1	12.50
Commitment to nursing	1	0.91	0	0	1	12.50
Client centered orientation	26	23.63	3	18.75	0	0
Preventive orientation or the philosophy of community health	19	17.27	1	6.25	3	37.50
Family centered service orientation	0	0	2	12.50	0	0

Reaction to Findings:

Criteria for Measurement:

A1

A2

A3

A4

A5

Competency:Category B -- Personal Traits and Characteristics

Reaction:

Agree? ______

Disagree? __________

Discussion:

Findings:

B. Personal traits and characteristics

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Average plus intelligence	2	1.82	0	0	1	12.50
Self-assurance	2	1.82	3	18.75	2	25.00
Good memory	2	1.82	0	0	0	0
Consistency	3	2.73	0	0	0	0
Common sense	4	3.64	1	6.25	1	12.50
Sense of humor	5	4.55	0	0	0	0
Enthusiasm	8	7.27	7	43.75	1	12.50
Versatility	14	12.72	6	37.50	1	12.50
Good natured, pleasant	0	0	1	6.25	0	0
Maturity (Attitude, acceptance of responsibility)	0	0	1	6.25	0	0
Empathy	0	0	3	18.75	1	12.50
Stability (Physical and mental health)	0	0	1	6.25	1	12.50
Consideration of others	0	0	1	6.25	0	0

Reaction to Findings:

Criteria for Measurement:

B1

B2

B3

B4

B5

B6

B7

B8

B9

B10

B11

B12

B13

Competency:Category C -- Technical Skills

Reaction:

Agree? ______

*D*isagree?__________

Discussion:

Findings:

C. Technical Skills

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Writing and recording skills	17	13.45	2	12.50	0	0
Driving skills	19	17.27	0	0	1	12.50
Screening and associated equipment skills	33	30.00	10	62.50	1	12.50
Nursing procedures*	33	30.00	10	62.50	1	12.50
Immunization skills	47	42.73	0	0	1	12.50

* May include immunization skills as well as basic nursing skills related to community health

Reaction to Findings:

Criteria for Measurement:

C1

C2

C3

C4

C5

Competency:Category D -- Direct Interaction with Clients

Reaction:

Agree? ______

Disagree?__________

Discussion:

Findings:

D. Direct Interaction with Clients

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Observation skills	5	4.55	0	0	0	0
Counselling skills	29	26.36	2	12.50	0	0
Interviewing skills	36	32.73	5	31.25	0	0
Interpersonal relationship skills	53	48.18	4	25.00	2	25.00
Communication skills	62	56.36	7	43.75	1	12.50
Assessment skills	73	66.36	8	50.0	1	12.50
Teaching skills	81	73.64	9	56.25	0	0

Reaction to Findings:

Criteria for Measurement:

D1

D2

D3

D4

D5

D6

D7

Competency:Category E -- Personal Skills

Reaction:

Agree? ______

Disagree? __________

Discussion:

Findings:

E. Personal Skills

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Resourcefulness as a skill	7	6.36	4	25.00	1	12.50
Maintaining confidentiality	8	7.27	0	0	0	0
Acting as a role model	9	8.18	1	6.25	0	0
Personal coping ability	11	10.00	0	0	1	12.50
Responsibility in the nursing situation	18	16.36	2	12.50	0	0
Decision making skills	23	20.91	3	18.75	0	0
Ability to act independently without supervision	26	23.64	7	43.75	1	12.50
Adaptability to changes in the work setting	32	29.09	7	43.75	1	
Ability to maintain competence	35	31.82	7	43.75	1	
Objectivity	0	0	1	6.25	0	0

Reaction to Findings:

Criteria for Measurement:

E1

E2

E3

E4

E5

E6

E7

E8

E9

E10

Competency:Category F -- Administration System Skills

Reaction:

Agree? ______

Disagree?__________

Discussion:

Findings:

F. Administration System Skills

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Leadership skills	5	4.55	1	6.25	0	0
Public relations skills	13	11.82	0	0	1	12.50
Evaluation skills	16	14.54	7	43.75	0	0
Ability to work within the system policies	23	20.91	6	37.50	2	25.00
Ability to work as a team member	52	47.27	6	37.50	1	12.50
Knowledge of and ability to use community resources	64	58.18	7	43.75	0	0
Organizational skills	84	76.36	6	37.50	1	12.50
Planning long range care	0	0	4	25.00	0	0
Establishing and utilizing a referral system	0	0	1	6.25	0	0

Reaction to Findings:

Criteria for Measurement:

F1

F2

F3

F4

F5

F6

F7

F8

F9

Competency:Category G -- Knowledge

Reaction:

Agree? ______

Disagree? __________

Discussion:

Findings:

G. Knowledge

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
First aid	3	2.73	0	0	0	0
Sexuality	4	3.64	0	0	0	0
Gerontology	5	4.55	0	0	0	0
Immunology	7	6.36	1	6.25	0	0
Previous experience	8	7.27	0	0	3	37.50
Group dynamics	14	12.73	3	18.75	0	0
Nutrition	21	19.09	1	6.25	1	12.50
Epidemiology	22	20.00	4	25.00	0	0
Growth and development	54	49.09	3	18.75	1	12.50
Nursing education or basic nursing training	69	62.73	8	50.00	5	62.50
Maternal and child health	0	0	1	0	0	0

Reaction to Findings:

Criteria for Measurement:

G1

G2

G3

G4

G5

G6

G7

G8

G9

G10

G11

III. Evaluation Methods

A. Present Evaluation Methods Used

	Nurses			Supervisors		
	#	Satis	Range	#	Satis	Range
None	21	1.00	1-2.5	0	0	0
Interviews	3	3.00	3	0	0	0
Informal feedback from coworkers	3	3.00	1-5	0	0	0
Supervisor observation	23	3.16	2-4	1	4	4
ACNARS	3	2.00	1-3	0	0	0
Self-evaluation	8	3.57	3-4	0	0	0
Combination self-evaluation and Supervisor observation	25	2.96	2-5	6	3.40	3-4
Record review	4	3.50	3-4	0	0	0
Rating form	18	3.25	2-5	7	3.41	3-4
Management By Objectives	11	3.54	2.5-5	1		
Peer review	2	2.50	2.5-4	0	0	0
Client survey	1	5.00	5	0	0	0

Reaction to Findings:

B. Respondent Choice for Evaluation

	Nurses #	Supervisors #
Questionnaire	1	0
Peer evaluation	10	0
Annual nursing supervisor/nurse conference	2	0
Client survey	8	0
Informal evaluation only	1	0
Self-evaluation	10	3
Combination self-evaluation, supervisor observation, and record review	19	2
Supervisor observation over an extended time period	0	4
Record review	1	0
MBO	4	4
Standard form used province wide	2	0
Specific to the position of staff nurse	2	0
Criterion based	1	0
Based on written job description	1	0

Comments:

IV. COMPARISONS TO OTHER PRACTICE AREAS

Compared to nurses working in other areas, in community health, the nurse:

1. requires more highly developed communication skills
2. requires more highly developed public relations skills
3. requires more highly developed teaching skills
4. requires more highly developed decision making skills
5. requires more highly developed organizational skills
6. requires more highly developed planning skills
7. must work independently with less backup and less direction
8. assists clients to help themselves rather than doing for the client
9. must be more flexible
10. is a generalist of nursing care as opposed to a specialist
11. uses a community orientation to illness rather than an individual patient outlook
12. works with "well" people as opposed to "sick"
13. must assess the community and be aware of its resources
14. must continually update
15. operates under a preventive rather than a curative orientation
16. requires driving skills
17. operates under a greater nursing risk
18. uses therapeutic counselling techniques as opposed to comforting techniques
19. plans long term care as opposed to short term care
20. offers non-compulsory services as opposed to compulsory services to a captive clientele in the hospital
21. sees slower, incremental responses to care
22. initiates care as opposed to following through on orders
23. is no different than nurses operating in other areas

V. APPLICABILITY OF AARN NURSING PRACTICE STANDARDS

A. Assessing -- Standard #1

Gathering of data on the health status of a client is accurate, systematic, communicated and recorded

Structure Criteria

The practice settings where nursing occurs should provide for:

1. written statements of the scope of nursing responsibilities.
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice.
3. utilization of an assessment framework in determining the data base. The data includes:
    a. past history
    b. present health history
    c. client's expectations of care
    d. any base line information affecting the client
4. relevant recording methods
5. adequate resources
6. accessibility of collected data
7. retrievability of collected data
8. coordination of collected data with that of other health team members
9. confidentiality of data

Process Criteria

The nurse:

1. collects subjective and objective data concerning the client's:
    a. health status
    b. view of his/her own health situation
    c. health results sought and their relationship to the client's life, health, and

his/her effective living

2. collects data utilizing astute observation, purposeful interview, valid and reliable techniques, a broad knowledge of human behavior, and understanding of what needs to be known and where to obtain the information
3. utilizes the necessary resources for collecting data which include:
    a. available expertise
    b. assessment framework
    c. relevant literature
    d. equipment and supplies
4. identifies immediate and long-term needs
5. records data
6. communicates data
7. updates data in relation to the client's change in health status
8. considers data confidential

Outcome Criteria

The client:

1. understands the reasons for data collection
2. actively contributes to the collection of data
3. validates accuracy of data

Which competencies are appropriate to this standard?

B. Assessing -- Standard #2

Nursing diagnoses are determined based on analysis of the collected data and are current, communicated and recorded

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources available for an accurate interpretation of data which include:
    a. norms for comparison
    b. available expertise
    c. relevant literature
4. accessibility of nursing diagnoses
5. utilization of relevant recording methods
6. retrievability of nursing diagnoses
7. confidential treatment of nursing diagnoses

Process Criteria

The nurse:

1. demonstrates knowledge of:
    a. normal human functioning
    b. current nursing theory
    c. scientific principles
    d. deviations from normal human functioning
    e. diagnoses and therapy determined by other health team members
    f. the client's capabilities and limitations
2. utilizes the necessary resources for interpretation of data
3. establishes the nursing diagnoses
4. validates the nursing diagnoses with the client

5. records the nursing diagnoses
6. updates the nursing diagnoses in relation to the client's health status
7. considers nursing diagnoses confidential

Outcome Criteria

The client:

1. validates the nursing diagnoses
2. indicates own limitations and capabilities
3. indicates a commitment to the plan of action

Which competencies are appropriate to this standard?

C. Planning -- Standard #3

Care goals are established from the nursing diagnoses and are current, communicated, coordinated and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for identifying long and short-term goals which include:
    a. norms for comparison
    b. available expertise
    c. relevant literature
4. recording of short-term goals for the client
5. recording of long-term goals for the client
6. accessibility of care goals to health team members
7. retrievability of care goals
8. recording of criteria to measure attainment of care goals
9. coordination of care goals with other health team members
10. confidentiality of care goals

Process Criteria

The nurse:

1. establishes care goals with the client on a priority basis
2. utilizes resources necessary to establish care goals
3. determines the congruency of care goals with those established by other team members
4. establishes criteria to evaluate the effectiveness of nursing actions for each care goal
5. records care goals

6. communicates care goals
7. alters care goals according to changes in health status
8. considers the care goals confidential

Outcome Criteria

The client:

1. validates the care goals
2. accepts shared responsibiltity for attaining care goals

Which competencies are appropriate to this standard?

D. Planning -- Standard #4

A plan for nursing action directed toward goal attainment is developed. This plan is current, coordinated, communicated and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for the development of nursing action which include:
    a. norms for comparison
    b. available expertise
    c. relevant literature
    d. material resources that are available, relevant and functional
4. recording of planned nursing actions
5. accessibility of planned nursing actions
6. retrievability of planned nursing actions
7. coordination of planned nursing actions with the plans of other health team members
8. confidentiality of planned nursing actions

Process Criteria

The nurse:

1. develops a plan of action with the client that is consistent with current knowledge and skills
2. considers possible actions and their consequences and makes a selection with the client
3. plans nursing actions utilizing approprite resources
4. contracts with the client the nurse's responsibility and the client's responsibility in relation to selected actions

5. establishes priority of planned nursing actions with the client
6. determines the congruency of planned nursing actions with those established by other team members
7. provides for continuity and coordination of care
8. records planned nursing actions
9. alters planned nursing actions according to changes in health status
10. considers the planned nursing actions confidential

Outcome Criteria

The client:

1. establishes a plan with the nurse for goal attainment
2. validates the planned nursing actions
3. indicates a commitment to the plan of action directed to goal achievement
4. contracts with the nurse those actions to be carried out by the client

Which competencies are appropriate to this standard?

E. Implementing -- Standard #5

Nursing actions based on the plan are implemented, communicated, coordinated and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for the implementation of nursing action which include:
    a. norms for comparison
    b. human resources who are approachable and appropriate for collaboration
    c. relevant literature
    d. material resources that are available, relevant and functional
4. recording of nursing actions
5. accessibility of recorded nursing actions
6. retrievability of recorded nursing actions
7. coordination of nursing actions with the actions of the other health team members
8. confidentiality of nursing actions

Process Criteria

The nurse:

1. carries out nursing measures consistent with scientific concepts, principles, predictable outcomes, established care goals and immediate and long-term needs
2. uses skills appropriate to the client's situation
3. uses nursing measures which provide for client safety, comfort and privacy
4. facilitates the client's acquisition of scientific knowledge and skills required to maintain his/her unique integrity
5. protects the client's rights
6. modifies nursing actions according to change in individual health status

7. informs client of changes in health status
8. assists client in adapting to physical, mental and social limitations as a different lifestyle is evolved
9. works with client and other health professionals to provide for continuity of care
10. initiates referrals based on identified needs and client's consent to selected community resources
11. records nursing actions
12. considers nursing actions confidential

Outcome Criteria

The client:

1. carries out those self-care actions agreed upon in the contract
2. understands need for specific nursing actions
3. participates in the learning process to use own resources more effectively to goal achievement
4. indicates changes in own health status
5. has knowledge of when and how to consult health care resources

Which competencies are appropriate to this standard?

F. Evaluating -- Standard #6

Evaluation of client's goal attainment and the effectiveness of nursing actions is continuous, communicated, and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for evaluation which include:
    a. the client
    b. human resources who are approachable and appropriate for collaboration
    c. relevant literature
    d. material resources that are available, relevant and functional
    e. norms for comparison
4. recording of evaluation
5. accessibility of evaluation
6. retrievability of evaluation
7. communication of evaluation with the actions of the other health team members
8. confidentiality of evaluation

Process Criteria

The nurse:

1. utilizes the established criteria for evaluation when
    a. collecting objective and subjective data from
        1) the client
        2) the health agency records
        3) his/her own observations
        4) other relevant personnel
    b. analyzing data

c. validating evaluation with client and others as necessary

2. records achievement of care goals and effectiveness of nursing actions
3. communicates achievement of goals and effectiveness of nursing actions
4. determines need for reassessment and/or need for revision of care plan
5. considers evaluation confidential

Outcome Criteria

The client:

1. demonstrates evidence of achievement of care goals or movement toward achievement of care goals
2. understands need for specific nursing actions
3. validates evaluation of care
4. participates in determining the need for reassessment and/or revision of the care plan

Which competencies are appropriate to this standard?

Overall comments:

Applicability of competencies to Nursing Practice Standards:

Applicability of Nursing Practice Standards to CHN Evaluation:

Appendix O - Questionnaire Second Round

INSTRUCTIONS TO RESPONDENTS

Thank you for agreeing to participate in this study on community health staff nurse evaluation. You will be reacting to 'competencies' generated in the first round of this study which took place during the summer.

Health units were randomly assigned to either phase 1 or phase 2. In phase 1, Board members (8/11), Nursing Supervisors (16/16), an staff nurses (110) responded to open-ended questions about competencies they considered necessary for a person to have in order to be successful in the position of community health nurse. They also reflected on their present and desired method of evaluation.

The package has been arranged so that you may proceed through the information step by step. You may find it preferable to do this in a group. If so, please indicate here the number of persons completing this package __________________________.

Again, thank you for your assistance. I look forward to your response.

VI. COMPETENCY LISTING

DEFINITIONS

The following definitions should be kept in mind as you react to the information on the following pages:

Competence will be defined as the quality or state of being functionally adequate or of having sufficient knowledge, judgment, skill, or strength (Schneider, 1979:1).

Competency will accordingly, be defined as an intellectual, attitudinal, and/or motor capability derived from a specified role and setting, and stated in terms of performance as a broad class or domain of behavior (Peterson, 1978:3). For the purposes of this exercise , competency will be operationally defined as those characteristics (knowledge, attitudes, or ways of doing) that a community health nurse must have to be considered *competent* in his/her job.

Criteria will be operationally defined as standards or guidelines that can be used to measure a specific competency.

You are asked to react to the 'competencies' listed on the yellow sheets. Your first reactions are the most valuable -- you are asked to *agree* or *disagree* that each statement is a competency necessary for a community health nurse to have to be considered *competent* in that position. These competencies are not considered to be absolutely necessary prior to employment but should be considered necessary once the nurse is actively practicing in community health and therefore could be evaluated as to their presence or absence.

Please circle the appropriate letter – A=Agree, D=Disagree following each statement. If more than one person is completing this package, each individual should complete a set of yellow sheets independently. The answers can then be combined in the next section of the package.

VII. INDIVIDUAL REACTION TO COMPETENCIES

A. Personal beliefs and attitudes	Agree	Disagree
A1 Positive attitude toward self and others	A	D
A2 Commitment to nursing	A	D
A3 Client centered orientation	A	D
A4 Preventive orientation or the philosophy of community health	A	D
A5 Family centered service orientation	A	D

B. Personal traits and characteristics	Agree	Disagree
B1 Average plus intelligence	A	D
B2 Self-assurance	A	D
B3 Good memory	A	D
B4 Consistency	A	D
B5 Common sense	A	D
B6 Sense of humor	A	D
B7 Enthusiasm	A	D
B8 Versatility	A	D
B9 Good natured, pleasant	A	D
B10 Maturity	A	D
B11 Empathy	A	D
B12 Stability	A	D
B13 Consideration	A	D

C. Technical Skills

	Agree	Disagree
C1 Writing and recording skills	A	D
C2 Driving skills	A	D
C3 Screening and associated equipment skills	A	D
C4 Nursing procedures related to community health	A	D
C5 Immunization skills	A	D

D. Direct Interaction with Clients

	Agree	Disagree
D1 Observation skills	A	D
D2 Counselling skills	A	D
D3 Interviewing skills	A	D
D4 Interpersonal relationship skills	A	D
D5 Communication skills	A	D
D6 Assessment skills	A	D
D7 Teaching skills	A	D

E. Personal Skills

	Agree	Disagree
E1 Resourcefulness as a skill	A	D
E2 Maintaining confidentiality	A	D
E3 Acting as a role model to clients	A	D
E4 Personal coping ability	A	D
E5 Responsibility in the nursing situation	A	D
E6 Decision making skills	A	D
E7 Ability to act independently without supervision	A	D
E8 Adaptability to changes in the work setting	A	D
E9 Aility to maintain competence	A	D
E10 Objectivity	A	D

F. Administration System Skills

	Agree	Disagree
F1 Leadership skills	A	D
F2 Public relations skills	A	D
F3 Evaluation skills	A	D
F4 Ability to work within the system policies	A	D
F5 Ability to work as a team member	A	D
F6 Knowledge of and ability to use community resources	A	D
F7 Organizational skills	A	D
F8 Planning long range care	A	D
F9 Establishing and utilizing a referral system	A	D

G. Knowldege

	Agree	Disagree
G1 First aid	A	D
G2 Sexuality	A	D
G3 Gerontology	A	D
G4 Immunology	A	D
G5 Previous experience	A	D
G6 Group dynamics	A	D
G7 Nutrition	A	D
G8 Epidemiology	A	D
G9 Growth and development	A	D
G10 Nursing education	A	D
G11 Maternal and child health	A	D

VIII. REACTION TO FINDINGS

Competency:Category A -- Personal Beliefs and Attitudes

Reaction: Please circle those "competencies" with which you do *not* agree:

A1 A2 A3 A4 A5

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern.

Findings:

A. Personal beliefs and attitudes	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Positive attitude toward self and others	6	5.45	2	12.50	1	12.50
Commitment to nursing	1	0.91	0	0	1	12.50
Client centered orientation	26	23.63	3	18.75	0	0
Preventive orientation or the philosophy of community health	19	17.27	1	6.25	3	37.50
Family centered service orientation	0	0	2	12.50	0	0

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

A1

A2

A3

A4

A5

Competency:Category B -- Personal Traits and Characteristics

Reaction: Please circle those "competencies" with which you do *not* agree:

B1 B2 B3 B4 B5 B6 B7

B8 B9 B10 B11 B12 B13

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern:

Findings:

B. Personal traits and characteristics

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Average plus intelligence	2	1.82	0	0	1	12.50
Self-assurance	2	1.82	3	18.75	2	25.00
Good memory	2	1.82	0	0	0	0
Consistency	3	2.73	0	0	0	0
Common sense	4	3.64	1	6.25	1	12.50
Sense of humor	5	4.55	0	0	0	0
Enthusiasm	8	7.27	7	43.75	1	12.50
Versatility	14	12.72	6	37.50	1	12.50
Good natured, pleasant	0	0	1	6.25	0	0

Maturity (Attitude, acceptance of responsibility)	0	0	1	6.25	0	0
Empathy	0	0	3	18.75	1	12.50
Stability (Physical and mental health)	0	0	1	6.25	1	12.50
Consideration of others	0	0	1	6.25	0	0

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

B1

B2

B3

B4

B5

B6

B7

B8

B9

B10

B11

260°

B12

B13

Competency:Category C -- Technical Skills

Reaction: Please circle those "competencies" with which you do *not* agree:

C1 C2 C3 C4 C5

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern:

Findings:

C. Technical Skills

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Writing and recording skills	17	13.45	2	12.50	0	0
Driving skills	19	17.27	0	0	1	12.50
Screening and associated equipment skills	33	30.00	10	62.50	1	12.50
Nursing procedures *	33	30.00	10	62.50	1	12.50
Immunization skills	47	42.73	0	0	1	12.50

* May include immunization skills as well as basic nursing skills related to community health

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

C1

C2

C3

C4

C5

Competency:Category D -- Direct Interaction with Clients

Reaction: **Please circle those "competencies" with which you do *not* agree:**

D1 D2 D3 D4 D5 D6 D7

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern:

Findings:

D. Direct Interaction with Clients

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Observation skills	5	4.55	0	0	0	0
Counselling skills	29	26.36	2	12.50	0	0
Interviewing skills	36	32.73	5	31.25	0	0
Interpersonal relationship skills	53	48.18	4	25.00	2	25.00
Communication skills	62	56.36	7	43.75	1	12.50
Assessment skills	73	66.36	8	50.0	1	12.50
Teaching skills	81	73.64	9	56.25	0	0

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

D1

D2

D3

D4

D5

D6

D7

Competency:Category E -- Personal Skills

Rea[illegible]on: Please circle those "competencies" with which you do *not* agree:

E1	E2	E3	E4	E5
E6	E7	E8	E9	E10

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern:

Findings:

E. Personal Skills

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Resourcefulness as a skill	7	6.36	4	25.00	1	12.50
Maintaining confidentiality	8	7.27	0	0	0	0
Acting as a role model	9	8.18	1	6.25	0	0
Personal coping ability	11	10.00	0	0	1	12.50
Responsibility in the nursing situation	18	16.36	2	12.50	0	0
Decision making skills	23	20.91	3	18.75	0	0
Ability to act independently without supervision	26	23.64	7	43.75	1	12.50
Adaptability to changes in the work setting	32	29.09	7	43.75	1	
Ability to maintain competence	35	31.82	7	43.75	1	

Objectivity	0	0	1	6.25	0	0

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

E1

E2

E3

E4

E5

E6

E7

E8

E9

E10

Competency:Category F -- Administration System Skills

Reaction: Please circle those "competencies" with which you do *not* agree:

F1 F2 F3 F4 F5

F6 F7 F8 F9

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern:

Findings:

F. Administration System Skills	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
Leadership skills	5	4.55	1	6.25	0	0
Public relations skills	13	11.82	0	0	1	12.50
Evaluation skills	16	14.54	7	43.75	0	0
Ability to work within the system policies	23	20.91	6	37.50	2	25.00
Ability to work as a team member	52	47.27	6	37.50	1	12.50
Knowledge of and ability to use community resources	64	58.18	7	43.75	0	0
Organizational skills	84	76.36	6	37.50	1	12.50
Planning long range care	0	0	4	25.00	0	0
Establishing and utilizing a referral system	0	0	1	6.25	0	0

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

F1

F2

F3

F4

F5

F6

F7

F8

F9

Competency:Category G - Knowledge

Reaction: Please circle those "competencies" with which you do *not* agree:

G1 G2 G3 G4 G5

G6 G7 G8 G9 G10

Discussion: Please note by number those competencies with which you do not agree or have concerns about and relate your reasons for that judgment or concern:

Findings:

G. Knowledge

	Nurses		Supervisors		Board Members	
	#	%	#	%	#	%
First aid	3	2.73	0	0	0	0
Sexuality	4	3.64	0	0	0	0
Gerontology	5	4.55	0	0	0	0
Immunology	7	6.36	1	6.25	0	0
Previous experience	8	7.27	0	0	3	37.50
Group dynamics	14	12.73	3	18.75	0	0
Nutrition	21	19.09	1	6.25	1	12.50
Epidemiology	22	20.00	4	25.00	0	0
Growth and development	54	49.09	3	18.75	1	12.50
Nursing education or basic nursing training	69	62.73	8	50.00	5	62.50

Maternal and child health	0	0	1	0	0	0

Reaction to Findings:

Criteria for Measurement: Please indicate the criteria by which you might "measure" the above competencies. This can be done by individual competency number or as a total category if seen as appropriate.

G1

G2

G3

G4

G5

G6

G7

G8

G9

G10

G11

IX. Evaluation Methods

Following is a presentation of the findings as to the present evaluation methods used in the health units of the respondents and the degree of satisfaction with that process as felt by those respondents. As these questions were open-ended, the frequency of occurrence cannot be listed as a percentage of the total respondents. Some offered multiple evaluative tools while others offered answers but stated they had not yet or never undergone an evaluation. It is an interesting comparison however to the next table which indicates the respondents choice for the ideal evaluation.

You are asked to examine both tables and make any comments desired as to the representativeness of the findings and of the extent to which one or a number of methods could utilize the competencies that you have examined in this package.

A. Present Evaluation Methods Used

	Nurses			Supervisors		
	#	Satis	Range	#	Satis	Range
None	21	1.00	1-2.5	0	0	0
Interviews	3	3.00	3	0	0	0
Informal feedback from coworkers	3	3.00	1-5	0	0	0
Supervisor observation	23	3.16	2-4	1	4	4
ACNARS	3	2.00	1-3	0	0	0
Self-evaluation	8	3.57	3-4	0	0	0
Combination self-evaluation and Supervisor observation	25	2.96	2-5	6	3.40	3-4
Record review	4	3.50	3-4	0	0	0
Rating form	18	3.25	2-5	7	3.41	3-4
Management By Objectives	11	3.54	2.5-5	1		
Peer review	2	2.50	2.5-4	0	0	0
Client survey	1	5.00	5	0	0	0

B. Respondent Choice for Evaluation

	Nurses #	Supervisors #
Questionnaire	1	0
Peer evaluation	10	0
Annual nursing supervisor/nurse conference	2	0
Client survey	8	0
Informal evaluation only	1	0
Self-evaluation	10	3
Combination self-evaluation, supervisor observation, and record review	19	2
Supervisor observation over an extended time period	0	4
Record review	1	0
MBO	4	4
Standard form used province wide	2	0
Specific to the position of staff nurse	2	0
Criterion based	1	0
Based on written job description	1	0

Comments:

X. COMPARISONS TO OTHER PRACTICE AREAS

Respondents in the first phase were asked if community health nursing competencies were different than those required of nurses working in other areas. The following comments were noted. Please circle the number of those statements with which you agree: Compared to nurses working in other areas (the hospital being most frequently cited), in community health the nurse:

1. requires more highly developed communication skills
2. requires more highly developed public relations skills
3. requires more highly developed teaching skills
4. requires more highly developed decision making skills
5. requires more highly developed organizational skills
6. requires more highly developed planning skills
7. must work independently with less backup and less direction
8. assists clients to help themselves rather than doing for the client
9. must be more flexible
10. is a generalist of nursing care as opposed to a specialist
11. uses a community orientation to illness rather than an individual patient outlook
12. works with "well" people as opposed to "sick"
13. must assess the community and be aware of its resources
14. must continually update
15. operates under a preventive rather than a curative orientation
16. requires driving skills
17. operates under a greater nursing risk
18. uses therapeutic counselling techniques as opposed to comforting techniques
19. plans long term care as opposed to short term care
20. offers non-compulsory services as opposed to compulsory services to a captive clientele in the hospital
21. sees slower, incremental responses to care
22. initiates care as opposed to following through on orders
23. is no different than nurses operating in other areas

XI. APPLICABILITY OF AARN NURSING PRACTICE STANDARDS

The AARN Nursing Practice Standards are based on the nursing process and are applicable to many areas of nursing practice. You are asked to examine each nursing practice standard in turn and note following which, if any, competencies listed in the first section of this package would fit under that particular standard. You do not have to assign all competencies to a standard and competencies may be assigned more than once if desired.

Following this, you will be asked to react generally to the feasibility and desire to use the AARN standards for the evaluation of community health nurses.

A. Assessing -- Standard #1

Gathering of data on the health status of a client is accurate, systematic, communicated and recorded

Structure Criteria

The practice settings where nursing occurs should provide for:

1. written statements of the scope of nursing responsibilities.
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice.
3. utilization of an assessment framework in determining the data base. The data includes:
   a. past history
   b. present health history
   c. client's expectations of care
   d. any base line information affecting the client
4. relevant recording methods
5. adequate resources
6. accessibility of collected data
7. retrievability of collected data

8. coordination of collected data with that of other health team members
9. confidentiality of data

Process Criteria

The nurse:

1. collects subjective and objective data concerning the client's:
    a. health status
    b. view of his/her own health situation
    c. health results sought and their relationship to the client's life, health, and his/her effective living
2. collects data utilizing astute observation, purposeful interview, valid and reliable techniques, a broad knowledge of human behavior, and understanding of what needs to be known and where to obtain the information
3. utilizes the necessary resources for collecting data which include:
    a. available expertise
    b. assessment framework
    c. relevant literature
    d. equipment and supplies
4. identifies immediate and long-term needs
5. records data
6. communicates data
7. updates data in relation to the client's change in health status
8. considers data confidential

Outcome Criteria

The client:

1. understands the reasons for data collection
2. actively contributes to the collection of data
3. validates accuracy of data

Which competencies are appropriate to this standard?

B. Assessing -- Standard #2

Nursing diagnoses are determined based on analysis of the collected data and are current, communicated and recorded

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources available for an accurate interpretation of data which include:
    a. norms for comparison
    b. available expertise
    c. relevant literature
4. accessibility of nursing diagnoses
5. utilization of relevant recording methods
6. retrievability of nursing diagnoses
7. confidential treatment of nursing diagnoses

Process Criteria

The nurse:

1. demonstrates knowledge of:
    a. normal human functioning
    b. current nursing theory
    c. scientific principles
    d. deviations from normal human functioning
    e. diagnoses and therapy determined by other health team members
    f. the client's capabilities and limitations
2. utilizes the necessary resources for interpretation of data
3. establishes the nursing diagnoses
4. validates the nursing diagnoses with the client

5. records the nursing diagnoses
6. updates the nursing diagnoses in relation to the client's health status
7. considers nursing diagnoses confidential

Outcome Criteria

The client:

1. validates the nursing diagnoses
2. indicates own limitations and capabilities
3. indicates a commitment to the plan of action

Which competencies are appropriate to this standard?

C. Planning -- Standard #3

Care goals are established from the nursing diagnoses and are current, communicated, coordinated and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for identifying long and short-term goals which include:
    a. norms for comparison
    b. available expertise
    c. relevant literature
4. recording of short-term goals for the client
5. recording of long-term goals for the client
6. accessibility of care goals to health team members
7. retrievability of care goals
8. recording of criteria to measure attainment of care goals
9. coordination of care goals with other health team members
10. confidentiality of care goals

Process Criteria

The nurse:

1. establishes care goals with the client on a priority basis
2. utilizes resources necessary to establish care goals
3. determines the congruency of care goals with those established by other team members
4. establishes criteria to evaluate the effectiveness of nursing actions for each care goal
5. records care goals

6. communicates care goals
7. alters care goals according to changes in health status
8. considers the care goals confidential

Outcome Criteria

The client:

1. validates the care goals
2. accepts shared responsibiltity for attaining care goals

Which competencies are appropriate to this standard?

D. Planning -- Standard #4

A plan for nursing action directed toward goal attainment is developed. This plan is current, coordinated, communicated and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for the development of nursing action which include:
    a. norms for comparison
    b. available expertise
    c. relevant literature
    d. material resources that are available, relevant and functional
4. recording of planned nursing actions
5. accessibility of planned nursing actions
6. retrievability of planned nursing actions
7. coordination of planned nursing actions with the plans of other health team members
8. confidentiality of planned nursing actions

Process Criteria

The nurse:

1. develops a plan of action with the client that is consistent with current knowledge and skills
2. considers possible actions and their consequences and makes a selection with the client
3. plans nursing actions utilizing approprite resources
4. contracts with the client the nurse's responsibility and the client's responsibility in relation to selected actions

5. establishes priority of planned nursing actions with the client
6. determines the congruency of planned nursing actions with those established by other team members
7. provides for continuity and coordination of care
8. records planned nursing actions
9. alters planned nursing actions according to changes in health status
10. considers the planned nursing actions confidential

Outcome Criteria

The client

1. establishes a plan with the nurse for goal attainment
2. validates the planned nursing actions
3. indicates a commitment to the plan of action directed to goal achievement
4. contracts with the nurse those actions to be carried out by the client

Which competencies are appropriate to this standard?

E. Implementing -- Standard #5

Nursing actions based on the plan are implemented, communicated, coordinated and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for the implementation of nursing action which include:
    a. norms for comparison
    b. human resources who are approachable and appropriate for collaboration
    c. relevant literature
    d. material resources that are available, relevant and functional
4. recording of nursing actions
5. accessibility of recorded nursing actions
6. retrievability of recorded nursing actions
7. coordination of nursing actions with the actions of the other health team members
8. confidentiality of nursing actions

Process Criteria

The nurse:

1. carries out nursing measures consistent with scientific concepts, principles, predictable outcomes, established care goals and immediate and long-term needs
2. uses skills appropriate to the client's situation
3. uses nursing measures which provide for client safety, comfort and privacy
4. facilitates the client's acquisition of scientific knowledge and skills required to maintain his/her unique integrity
5. protects the client's rights
6. modifies nursing actions according to change in individual health status

7. informs client of changes in health status
8. assists client in adapting to physical, mental and social limitations as a different lifestyle is evolved
9. works with client and other health professionals to provide for continuity of care
10. initiates referrals based on identified needs and client's consent to selected community resources
11. records nursing actions
12. considers nursing actions confidential

Outcome Criteria

The client

1. carries out those self-care actions agreed upon in the contract
2. understands need for specific nursing actions
3. participates in the learning process to use own resources more effectively to goal achievement
4. indicates changes in own health status
5. has knowledge of when and how to consult health care resources

Which competencies are appropriate to this standard?

F. Evaluating -- Standard #6

Evaluation of client's goal attainment and the effectiveness of nursing actions is continuous, communicated, and recorded.

Structure Criteria

The practice settings where nursing occurs provide for:

1. written statements of the scope of nursing responsibilities
2. learning experiences and support for nurses which promote professional growth and are consistent with current conceptual frameworks for nursing practice
3. resources necessary for evaluation which include:
    a. the client
    b. human resources who are approachable and appropriate for collaboration
    c. relevant literature
    d. material resources that are available, relevant and functional
    e. norms for comparison
4. recording of evaluation
5. accessibility of evaluation
6. retrievability of evaluation
7. communication of evaluation with the actions of the other health team members
8. confidentiality of evaluation

Process Criteria

The nurse:

1. utilizes the established criteria for evaluation when
    a. collecting objective and subjective data from
        1) the client
        2) the health agency records
        3) his/her own observations
        4) other relevant personnel
    b. analyzing data

   c. validating evaluation with client and others as necessary

2. records achievement of care goals and effectiveness of nursing actions
3. communicates achievement of goals and effectiveness of nursing actions
4. determines need for reassessment and/or need for revision of care plan
5. considers evaluation confidential

Outcome Criteria

The client:

1. demonstrates evidence of achievement of care goals or movement toward achievement of care goals
2. understands need for specific nursing actions
3. validates evaluation of care
4. participates in determining the need for reassessment

Overall Comments:

Applicability of competencies to Nursing Practice Standards:

Applicability of Nursing Practice Standards to CHN Evaluation: